

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 5 1959

59-033824

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8758**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If outside, give location) 4433 Gravois, 16	

3. NAME OF DECEASED (Type or print) First DANIEL Middle Geisel Last Geisel			4. DATE OF DEATH Month 9 Day 20 Year 59			
5. SEX MALE	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-20-59	9. AGE (last birthday)	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Ray Henry Geisel			13b. MOTHER'S MAIDEN NAME Jill Marie DeMarco		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Jill Marie Geisel - 4433 Gravois, 16		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Hypoxia			
DUE TO (b) Shoulder Dystocia			
DUE TO (c) Anencephaly			750x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) N/A
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year N/A	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 1030 AM to 145 AM 9/20/59 and last saw her alive on 9/20/59 Death occurred at 145 AM 9/20/59 m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE John E. Indee M.D. (Degree or title)		22b. ADDRESS 1305 S. Grand		22c. DATE SIGNED 9/20/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sep 23, 59	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul	23d. LOCATION (City, town, or county) (State) St. Louis Mo	
24. FUNERAL DIRECTOR ADDRESS E. J. Schnur 3125 Lafayette		25. DATE RECD. BY LOCAL REG. SEP 23 59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Not Embalmed
Joe F. Hallman
Licensed Embalmer No. _____

P. O. Address 3125 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.