

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042820

FILED VS DEC 8 1959

317

Primary Registration District No. 543

Registrar's No. 9050

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jennings</b>		Length of stay in 1b <b>14 Months</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) Home HOSPITAL OR INSTITUTION <b>High Towers Nursing</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>19 N. Spring Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>N.</b> Last <b>BOYD</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>16</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-11-1869</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Aux Vasse, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Detchemendy</b>			13b. MOTHER'S MAIDEN NAME <b>Ellen Sherlock</b>			14. NAME OF HUSBAND OR WIFE <b>Late Aaron C. Boyd</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ferguson,</b> Address <b>Mo.</b> <b>Laurence Boyd 101 S. Elizabeth</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>420.0</b>								
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____						
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <b>Sept 16, 1958</b> to <b>Nov 16, 1959</b> and last saw her alive on <b>Nov 12, 1959</b> Death occurred at <b>5:30 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Lewis Luttman MD</b>				22b. ADDRESS <b>8231 Clayton Rd (17)</b>			22c. DATE SIGNED <b>11/17/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal (Mtr)</b>		23b. DATE <b>Nov. 18, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetary</b>		23d. LOCATION (City, town, or county) (State) <b>Fredericktown, Mo.</b>			
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>				25. DATE RECD. BY LOCAL REG. <b>11-17-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy MD</b>		

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed A. W. Steward

Licensed Embalmer No. 4007

P. O. Address H. L. L. L. L. L.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.