

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

EILED VS JAN - 4 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **211901**

RECEIVED

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, MISSOURI		Length of stay in 1b	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST LOUIS CITY HOSP # 1		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2859^E INDIANA Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Warren Middle Last Erney			4. DATE OF DEATH Month December Day 21st Year 1959	
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JUNE 26 1888	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Moulder	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME DAVID ERNEY	13b. MOTHER'S MAIDEN NAME CATHERINE REINHARDT	14. NAME OF HUSBAND OR WIFE MARY ERNEY
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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 MARY ERNEY 2859^E INDIANA
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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) Pulmonary Edema		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Congestive Failure	
	DUE TO (c) Arteriosclerotic Heart Disease	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Branchopneumonitis, Pleural Effusion	PART III. If deceased was female was there a pregnancy in last 90 days 4200 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year
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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
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21. I attended the deceased from **Dec 20, 1959 11A.M.** to **Dec 21st, 1959** and last saw her/him alive on **Dec 21st, 1959**
Death occurred at **5:25 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James W. Handy Jr. M.D.	22b. ADDRESS 1515 Lafayette Avenue	22c. DATE SIGNED 12-21-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE DEC. 24 1959	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS CO, Mo
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24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois	25. DATE RECD. BY LOCAL REG. DEC 23 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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M. J. 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James O. Will

Licensed Embalmer No. 4347

P. O. Address 2906

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.