

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 3 1 0

FILED VS JAN - 4 1968

ENDED

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 3495 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEBSTER GROVES</u> | Length of stay in 1b <u>3 YEARS</u> | c. CITY OR TOWN <u>WEBSTER GROVES</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DDA. STL Co HOSP</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>856 MARSHALL AVE</u> |

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| 3. NAME OF DECEASED (Type or print) First <u>PETER</u> Middle Last <u>RENE</u> | | | 4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>'59</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-2-1884</u> | 9. AGE (last birthday) <u>75</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOCK CLERK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>ELY-WALKER D.C.</u> | 11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>CARL RENE</u> | | 13b. MOTHER'S MAIDEN NAME <u>SOPHIE ANDERSON</u> | | 14. NAME OF HUSBAND OR WIFE <u>ANNIE RENE</u> | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>unk.</u> | 17. INFORMANT Address <u>Katherine Rene 852 Marshall N 9 Mo</u> |
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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) | <u>Arteriosclerotic coronary disease</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | <u>Senile dementia</u> | |
| DUE TO (b) | <u>Total loss of vision</u> | |
| DUE TO (c) | | |
| 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 |

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| 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 | | |

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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 |
| 21. I attended the deceased from <u>2-17-58</u> to <u>Dec. 15. 59</u> and last saw him alive on <u>Dec. 15. 59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | |

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| 22a. SIGNATURE (Degree or title) <u>[Signature] M.D.</u> | 22b. ADDRESS <u>7266 Marchester</u> | 22c. DATE SIGNED <u>12-29-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>12-31-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST MARCUS</u> |
| 23d. LOCATION (City, town, or county) (State) <u>GARDENVILLE 73 MO</u> | | |

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| 24. FUNERAL DIRECTOR ADDRESS <u>MITTELOBERG WEBSTER GROVES MO</u> | 25. DATE RECD. BY LOCAL REG. <u>12-29-59</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |
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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 John J. Harris

Licensed Embalmer No. 4108

P. O. Address St. Louis

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.