

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 22 1960

60-003233

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 254**

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		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ANTHONY'S Hosp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3642 BOTANICAL		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First GRACE Middle CARLISLE Last				4. DATE OF DEATH Month JAN Day 7 Year 1960									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-8-1879		9. AGE (last birthday) 80		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) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME CHARLES Mc MORROW				13b. MOTHER'S MAIDEN NAME MARY RedFERN				14. NAME OF HUSBAND OR WIFE JOHN CARLISLE (DECD)					
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. None		17. INFORMANT VERGIL CARLISLE		Address 3642 BOTANICAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Vasculitis Heart Disease DUE TO (c) 4201										INTERVAL BETWEEN ONSET AND DEATH July 6-1960			
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 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.) 4201									
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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 Nov 15 1958 to Jan 6 1960 and last saw her alive on Jan 6 - 1960 Death occurred at 8:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE H. J. Moore (Degree or title) MD				22b. ADDRESS 917-5018				22c. DATE SIGNED 1-8-1960					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE JAN 9, 1960		23c. NAME OF CEMETERY OR CREMATORY LAKewood PARK Cem.				23d. LOCATION (City, town, or county) ST. LOUIS Co		(State) Mo			
24. FUNERAL DIRECTOR Thomas Kutz ADDRESS 2406 Grannis				25. DATE RECD. BY LOCAL REG. JAN 8 1960		26. REGISTRAR'S SIGNATURE Loan 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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.