

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-004066

FILED VS. JAN 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 264 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Chronic Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3619 Missouri</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Simeral</u>			4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>May 9, 1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Benton County, Arkansas</u>	
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>			13a. FATHER'S NAME <u>John Scribner</u>		
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Frank</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Arleen Huff 3603 S. Jefferson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (<u>Fracture of Right Hip</u> <u>Generalized Arterio sclerosis</u> 904.7 21 DUE TO (a) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Suffered in fall</u>				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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <u>Slipped at chronic hospital etc. at about</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>12/1/59</u> <u>December 1/27 1959.</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>13 Hosp.</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis Mo.</u>	COUNTY	STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Patrick Taylor Caroux</u>			22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>1.6.60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 7, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Lutheran Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Granite City, Illinois</u>		
24. FUNERAL DIRECTOR ADDRESS <u>C. Hoffmeister Mortuaries</u> <u>7814 S. Broadway</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 5 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>mjb</u>		

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 Shenne

Licensed Embalmer No. 4199
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.