

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012419

FILED VS APR 4 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 3227** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b <b>2 wks</b>	c. CITY OR TOWN <b>St Johns</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8829 Kathlyn</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>J.</b> Last <b>Callier</b>			4. DATE OF DEATH Month <b>3</b> Day <b>19</b> Year <b>60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/21</b>	9. AGE (last birthday) <b>38</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Community F Dept</b>	11. BIRTHPLACE (City and state or country) <b>St Louis Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Daniel Callier</b>		13b. MOTHER'S MAIDEN NAME <b>Marie Kahmke</b>		14. NAME OF HUSBAND OR WIFE <b>Lenora Callier</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>495-12-4678</b>	17. INFORMANT Address <b>Lenora Callier 8829 Kathlyn</b>		

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 <b>Abt. 5 yrs.</b>
IMMEDIATE CAUSE (a) <b>Chronic renal failure</b>		Several mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Uremia</b>	
	DUE TO (c) <b>592x</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 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.)	
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>November, 1959</b> , to <b>3/19/60</b> and last saw her/him alive on <b>3/19/60</b> Death occurred at <b>4:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>FR Bradley M.D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>3/20/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3/23/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>Ortmann F Home 9222 Lackland Overland Mo</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 21 1960</b>	26. REGISTRAR'S SIGNATURE <b>Leon Smith, M.D.</b> <i>m83</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

**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 Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

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.