

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013487

FILED VS. MAR 30 1960 317 Primary Registration District No. 544 Registrar's No. 814

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ST. LOUIS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JEFFERSON				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKWOOD		Length of stay in 1b HRS.		c. CITY OR TOWN HIGH RIDGE		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. JOSEPH HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) RT. 2, BOX 231		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle G. Last ROBERT				4. DATE OF DEATH Month MARCH Day 6, Year 1960				
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 7/9/1897	9. AGE (last birthday) 62	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) CRANE OPERATOR			10b. KIND OF BUSINESS OR INDUSTRY GREAT LAKES CORBAN		11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME FRANK ROBERT			13b. MOTHER'S MAIDEN NAME MARCELIA GAMACHE			14. NAME OF HUSBAND OR WIFE DELIA ROSE BAKER ROBERT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW # 1, WW # 2			16. SOCIAL SECURITY NO. 492 03 7686		17. INFORMANT Address DELIA ROBERT RT. 2, BOX 231 HIGH RIDGE, MO.			
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 OCCLUSION							INTERVAL BETWEEN ONSET AND DEATH 2 Hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTEROSCLEROTIC HEART DISEASE							1 hr	
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Previous Myocardial Infarction						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 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 _____ 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 7/29/59 to 3/6/60 and last saw ^{her} _{him} live on 2/27/60 Death occurred at 8:50 AM , _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Charles St. Louis				22b. ADDRESS 7430 VIRGINIA AVE		22c. DATE SIGNED 3/7/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAR. 9, 1960	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK		23d. LOCATION (City, town, or county) (State) AFTON, MISSOURI				
24. FUNERAL DIRECTOR ADDRESS C. HOPFMEISTER MORTUARIES 7814 SO. BROADWAY ST. LOUIS, MO.			25. DATE RECD. BY LOCAL REG. 3-9-60		26. REGISTRAR'S SIGNATURE John C. Murphy 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 Bill C. Branson

Licensed Embalmer No. 4464

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.