

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013528

FILED VS MAR 30 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 985 STATE FILE NUMBER

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY <u>St. Louis</u> | | b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u> | | a. STATE <u>Mo.</u> | | b. COUNTY <u>St. Louis</u> | |
| Length of stay in lb <u>1 Day</u> | | c. CITY OR TOWN <u>Kirkwood</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>365 S. Harrison Rear</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph De Vault</u> | | | | 4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 10, 1896</u> | |
| 9. AGE (last birthday) <u>64</u> | | IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> | | IF UNDER 24 HR Hours <u>10</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Kirkwood Mo.</u> | | 11. BIRTHPLACE (City and state or country) <u>U.S.A</u> | | 12. CITIZEN OF WHAT COUNTRY |
| 13a. FATHER'S NAME <u>James De Vault</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Lula Gibson</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Francis DeVault</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. <u>499-03-5309 H.A.</u> | | 17. INFORMANT <u>Francis DeVault</u> | | Address <u>365 S. Harrison</u> |
| 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>Cerebral Thrombosis</u> | | | | | | | |
| DUE TO (b) <u>Hypertensive Cardiovascular disease</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) <u>Asthma, Obesity</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 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 <u>3-20-1960</u> to <u>3-21-1960</u> and last saw her/him alive on <u>3-21-1960</u> Death occurred at <u>10:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Mois Gordon M.D.</u> | | | | 22b. ADDRESS <u>601 S. Brentwood Blvd.</u> | | 22c. DATE SIGNED <u>3-24-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Mar. 28, 1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Crestwood Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>John W. Hemphill</u> | | | ADDRESS <u>408 S. Fillmore</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-24-60</u> | | 26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leaffin E Cooper

Licensed Embalmer No. 4600

P. O. Address St. Louis, Mo.

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.