

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017245

FILED VS APR 18 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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 <u>48 YRS.</u>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PARK LANE HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4116 N. 20TH ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>A.</u> Last <u>QUIBEL</u>			4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1960</u>			
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>8-10-1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>VIENNA, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>CALVIN COPELAND</u>	13b. MOTHER'S MAIDEN NAME <u>PURLINA WILDS</u>	14. NAME OF HUSBAND OR WIFE <u>JOSEPH S. QUIBEL</u>
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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>NONE</u>	17. INFORMANT <u>JOSEPH S. QUIBEL</u>	Address <u>4116 N. 20TH ST.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), <u>diabetic coma, cerebral hemorrhage</u>)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma, Cerebral hemorrhage</u>		
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.	DUE TO (b) <u>hemorrhage</u>	
	DUE TO (c) <u>Sarcoma of pancreas 157x</u>	

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
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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.)
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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
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21. I attended the deceased from 3/24/60 to 4-5-60 and last saw her alive on 4-5-60
Death occurred at 115 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wm G. King M.D.</u>	22b. ADDRESS <u>8201 North Broadway St. Louis</u>	22c. DATE SIGNED <u>4-6-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4-8-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VIENNA CEMETERY</u>	23d. LOCATION (City, town, or county) <u>VIENNA, MO.</u>
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24. FUNERAL DIRECTOR <u>SUEDMEYER & SONS</u>	ADDRESS <u>3934 N. 20TH ST.</u>	25. DATE RECD. BY LOCAL REG. <u>APR 6 1960</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjb

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 Elton H. Penelun

Licensed Embalmer No. 4283

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.