

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021809

FILED VS MAY 31 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1431

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILL</u> b. COUNTY <u>COOK</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b <u>VISIT</u>	c. CITY OR TOWN <u>GLENVIEW</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>ST. LOUIS COUNTY HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>906 QUEEN'S LANE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>SHIRLEY ANN PAGE</u>			4. DATE OF DEATH Month Day Year <u>APRIL 30 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-38</u>	9. AGE (last birthday) <u>21</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PROF. BUS. ACCTG.</u>		11. BIRTHPLACE (City and state or country) <u>FULTONVILLE N.Y.</u>		
10c. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>GUY F. PAGE</u>		13b. MOTHER'S MAIDEN NAME <u>EMILY R. BADGER</u>		
14. NAME OF HUSBAND OR WIFE <u>NONE</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>351-32-1806</u>		
17. INFORMANT <u>NORVAL M. PAGE</u>		Address <u>3745 W. CLAY ST. CHARLES MO.</u>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain injury and multiple other injuries</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

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 checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Passenger in car involved in collision with another motor vehicle</u>
20c. TIME OF INJURY Hour <u>10:00</u> Month, Day, Year <u>4/30/60</u> p.m. <u>XX</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>highway</u>	20f. CITY, TOWN, OR LOCATION <u>Hazelwood</u>	COUNTY <u>St. Louis</u>	STATE <u>Missouri</u>
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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 <u>Raymond H. Harris</u> (Degree or title) <u>Coroner Clayton, Mo.</u>	22b. ADDRESS <u>ST. CHARLES MO.</u>	22c. DATE SIGNED <u>5/11/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>MAY 2, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d. LOCATION (City, town, or county) (State) <u>ST. CHARLES MO.</u>
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24. FUNERAL DIRECTOR <u>C.L. PRINSTER.</u>	ADDRESS <u>ST. CHARLES, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 2 1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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 Howard O. Kessler

Licensed Embalmer No. 463

P. O. Address Wentz

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.