

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 12 1960

=60-022502

STATE FILE NUMBER

Registration District No. 389 Primary Registration District No. 5161 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>New Bloomfield</u>		Length of stay in 1b <u>9 yr</u>		c. CITY OR TOWN <u>St. Paul</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Margaret</u> Last <u>Dyer</u>			4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>10-22-1865</u>	9. AGE (last birthday) <u>94</u>	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)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St Paul Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William C Dyer</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret McMenamy</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)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ann Margaret Williams - Mo.</u> Address <u>New Bloomfield</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>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>the week</u>	
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 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.		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>July 2, 1960</u> to <u>July 9, 1960</u> and last saw her/him alive on <u>July 9, 1960</u> Death occurred at <u>16.20</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Emerlinda M.D.</u> (Degree or title)				22b. ADDRESS <u>New Bloomfield Mo</u>		22c. DATE SIGNED <u>July 4, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-12-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Paul</u>		23d. LOCATION (City, town, or county) <u>St. Paul Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>O'Fallon Mortuary Inc</u> ADDRESS <u>Charles J Callahan</u>			25. DATE RECD. BY LOCAL REG. <u>O'Fallon Mo. 7-9-60</u>		26. REGISTRAR'S SIGNATURE <u>LeRoy Claypool</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 Charles J. Colloby

Licensed Embalmer No. Perm

P. O. Address O'Fallon

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.