

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032928

FILED VS SEP 14 1960
 Registration District No. _____

318

Primary Registration District No. 1003

Registrar's No. 8482

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>Mo.</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST. LOUIS</u>		Length of stay in 1b <u>1 yr.</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>CARDINAL GLENNON MEMORIAL</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3908 A Folsom 10</u>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>DUANE</u> Last <u>STONE</u>				4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>60</u>			
5. SEX <u>MALE</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>8/17/59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RICHMOND HTS. MO.</u>		9. AGE (last birthday) <u>1 yr.</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____	
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>LEONARD</u>		13b. MOTHER'S MAIDEN NAME <u>RUTH DIVINNY</u>	
13c. MOTHER'S MAIDEN NAME <u>LEONARD</u>		14. NAME OF HUSBAND OR WIFE <u>LEONARD</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>NONE</u>	
17. INFORMANT <u>LEONARD STONE, 3908 Folsom</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>3rd Burn. Overwhelming sepsis</u> DUE TO (b) <u>3rd Burns</u> DUE TO (c) <u>917.0 - 17</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u> <u>11 da.</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	
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 checked="" type="checkbox"/> NO <input 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.) <u>Allegedly sat in sink full of hot water</u>			
20c. TIME OF INJURY Hour <u>11</u> a.m. <u>11</u> p.m.		Month, Day, Year <u>8 60</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>17 HOME</u>	
20f. CITY, TOWN, OR LOCATION <u>ST. LOUIS</u>		COUNTY <u>ST. LOUIS</u>		STATE <u>MO.</u>		21. I attended the deceased from <u>August 15</u> to <u>Aug 26, 1960</u> and last saw her/him alive on <u>Aug. 26</u> Death occurred at <u>8:15</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>William George Ship MD.</u>		(Degree or title)		22b. ADDRESS <u>Cardinal Glennon Hospital</u>		22c. DATE SIGNED <u>8/27/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>8-29-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>ALBERT H. HOPPE, INC. 4700 WASHINGTON</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>AUG 29 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loant Smith. M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*OK by
Paul J. Corn
Deputy Cor.*

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 Greg W. Welton

Licensed Embalmer No. 357

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.