

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033371

FILED VS SEP 12 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2339 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) OR TOWN <u>Lemay</u>		a. STATE <u>Mo.</u>		b. COUNTY admission)	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mt. St. Rose Hospital</u>		Length of stay in 1b <u>1 Yr.-2 1/2 Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>5230 Murdoch Ave.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month Day Year	
First <u>JOHN</u> Middle <u>J.</u> Last <u>CUMMINS</u>			Month <u>Aug.</u> Day <u>4</u> Year <u>1960</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>8-6-1869</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper (Retired) National Biscuit Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Lawrence Cummins</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Bell</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-26-0377</u>		17. INFORMANT Address <u>Gerald Roach 5230 Murdoch Ave.</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>Arteriosclerotic Cardiovascular Disease</u>						<u>unknown</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.	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>20 May 59</u> to <u>4 Aug 60</u> and last saw him alive on <u>25 July 60</u> . Death occurred at <u>8:30 P.</u> on the date stated above, and to the best of my knowledge from the causes stated.							
22a. SIGNATURE (Degree or title) <u>John J. McClure MD</u>				22b. ADDRESS <u>4401 Hampton</u>		22c. DATE SIGNED <u>5 Aug 60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Aug. 6, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S.Kingshighway Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>8-5-60</u>		26. REGISTRAR'S SIGNATURE <u>James M. [Signature]</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

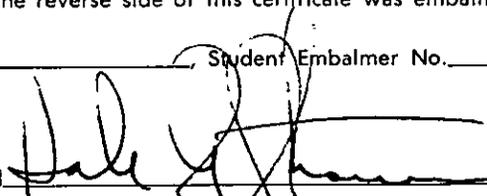
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

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.