RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-044106

FILED VS DEC 14 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11767 STATE FILE NUMBER

ED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Length of stay in 1b

c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. JOHNS HOSP. — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 1393 HODIAMONT — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First JASPER Middle LEROY Last RENFRO

4. DATE OF DEATH Month DEC, Day 6, Year 1960

5. SEX MALE

6. COLOR OR RACE WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4/4/1905

9. AGE (last birthday) 55 — 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) MAIN MAN & CHAUFFEUR

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) ILLINOIS

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME FRANK RENFRO

13b. MOTHER'S MAIDEN NAME ROSENE GREGG

14. NAME OF HUSBAND OR WIFE ALTA RENFRO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. #

17. INFORMANT Address ALTA RENFRO 1393 a HODIAMONT AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 48 hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Generalized Carcinomatosis of Lung

DUE TO (c) Carcinoma of Lung — 9 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) Duodenal ulcer c̄ Pyl. obs. Lt Pneumonectomy Lt Thoracoplasty, Empyema

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) — 163x

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year —

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 2-19-60, to 12-6-60 and last saw her/him alive on 12-5-60

Death occurred at 6:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph V. O'Donnell M.D.

22b. ADDRESS 539 N. Grand St Louis 3, Mo

22c. DATE SIGNED 12/7/60

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL MOTOR

23b. DATE 12/8/60

23c. NAME OF CEMETERY OR CREMATORY UNION GROVE CEMETERY

23d. LOCATION (City, town, or county) (State) GREENVILLE ILLINOIS

24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NAT'L BRIDGE

25. DATE RECD. BY LOCAL REG. DEC 7 1960

26. REGISTRAR'S SIGNATURE Carl Smith. M.D.

DOCUMENT

BY AFFIDAVIT OF

Dr Joe
Sjonnell
539 No Grand
Je 56930
11am Wed

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_____ Signed M W Rieter

Signature of Student Embalmer

Licensed Embalmer No. 4865

P. O. Address St Louis 2

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