

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-044717

ED VS. DEC. 1 1960

DED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3337 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Koch, Missouri</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>157 days</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>Robt. Koch Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4028 Enright</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clovis</u> Middle <u>Green</u> Last			4. DATE OF DEATH Month <u>11-</u> Day <u>15</u> Year <u>1960</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>N-white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-12</u>	9. AGE (last birthday) <u>48 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Mississippi</u>	12. CITIZEN OF WHAT COUNTRY <u>US A</u>
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13a. FATHER'S NAME <u>Sam Green</u>	13b. MOTHER'S MAIDEN NAME <u>Jessie Pointer</u>	14. NAME OF HUSBAND OR WIFE <u>Choice William-Dec.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>302-10-4751</u>	17. INFORMANT Address <u>Koch Hosp. Record, Koch, Missouri</u>
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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>Carcinoma involving liver, left petrous bone - metastatic, and lymph nodes</u>	DUE TO (b)	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>2 Pulmonary tuberculosis</u>	

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"/> N. <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u>4:30</u> a.m. p.m.	Month, Day, Year <u>6-11-60</u>
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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
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21. I attended the deceased from 6-11-60 to 11-15-60 and last saw her/him alive on 11-15-60
Death occurred at 4:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Bernard Friedman M.D.</u>	22b. ADDRESS <u>Robt. Koch Hosp. Koch, Mo.</u>	22c. DATE SIGNED <u>11-16-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	23d. LOCATION (City, town, or county) (State) <u>Carbondale, Illinois</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Algee Funeral Home Carbondale, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>11-16-60</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Murphy M.D.</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 Ronald Jamison

Licensed Embalmer No. 5011

P. O. Address St. Louis

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.