

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048141

OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3707 STATE FILE NUMBER

FILED VS JAN 5 1967

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> Length of stay in 1b <u>DOA</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>Rock Hill</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2456 Pocahontas</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>F.</u> Last <u>BIXLER</u>			4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-1914</u>	9. AGE (last birthday) <u>56 46</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) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freight Transp.</u>		11. BIRTHPLACE (City and state or country) <u>Pillsburg, Ks.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Earl Q. Bixler</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Lucetta Shipman</u>			14. NAME OF HUSBAND OR WIFE <u>Vivian Bixler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Vivian Bixler,</u> Address <u>above</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>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u> <u>7 1/2 yrs</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 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>10/18/1954</u> , to <u>Present</u> and last saw ^{her} him alive on <u>4/30/60</u> Death occurred at <u>11:30 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. B. Smith M.D.</u>				22b. ADDRESS <u>1617 Brentwood Blvd.</u>		22c. DATE SIGNED <u>12/23/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-23-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ozark Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Joplin, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>JAY B. SMITH, Maplewood, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-23-60</u>		26. REGISTRAR'S SIGNATURE <u>J. B. Smith M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Funeral Director

18 27 6 1 WLT ST

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 W. J. Burgess

Licensed Embalmer No. 4029

P. O. Address Maple

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