

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048333

FILED IN JAN 5 1961 317 Registration District No. 500 Primary Registration District No. Registrar's No. 3640 STATE FILE NUMBER

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Manchester | | Length of stay in 1b 6 weeks | c. CITY OR TOWN Richmond Hgts. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Manchester Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 7464 Hoover Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | | |
|---|----------------------------------|---|--|---|---|--|
| 3. NAME OF DECEASED (Type or print) First HERBERT Middle GUEMPEL Last GUEMPEL | | | 4. DATE OF DEATH Month Dec. Day 17th Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 18, 1888 | 9. AGE (last birthday) 72 | IF UNDER 1 YEAR Months 2 Days 29 | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY St. Mary's Infirmary | | 11. BIRTHPLACE (City and state or country) Kansas | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Michael Guempel | | 13b. MOTHER'S MAIDEN NAME Mary Penrod | | 14. NAME OF HUSBAND OR WIFE Mae Guempel | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 498-10-9232 | | 17. INFORMANT Address Roland Siebert 7464 Hoover Ave. | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Urinary Bladder | | INTERVAL BETWEEN ONSET AND DEATH about 1 year |
| 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) Seizure | | |

| | |
|--|--|
| 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 **Nov. 7, 1960** to **Dec. 16, '60** and last saw ^{her} _{him} live on **Dec. 16th, 1960**
Death occurred at **2:30 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|---|-------------------------------------|
| 22a. SIGNATURE (Degree or title) Ralph W. Laffey D.O. | 22b. ADDRESS Box 122, Manchester, Mo. | 22c. DATE SIGNED 12-17-60 |
|---|---|-------------------------------------|

| | | | |
|--|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Dec. 19, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
|--|-----------------------------------|---|--|

| | | | |
|--|------------------------------------|---|---|
| 24. FUNERAL DIRECTOR A.H. BOCKLAGE | ADDRESS 6536 Clayton Rd. | 25. DATE RECD. BY LOCAL REG. 12-17-60 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
|--|------------------------------------|---|---|

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 Wm Binkley

Licensed Embalmer No. 361

P. O. Address Harris

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.