SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-007066
STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 449

FILED VS MAR 2 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Length of stay in 1b D.O.A.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hosp. — Inside Limits Yes # No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN St. Ann — Inside Limits Yes # No ☐
d. STREET ADDRESS (If outside, give location) 10361 St. Charles Rd. — Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print) First Gerald Middle A. Last Archambault
4. DATE OF DEATH Month Feb. Day 13 Year 1961
5. SEX Male
6. COLOR OR RACE White
7. Married # Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 3)4)1902
9. AGE (last birthday) 58 — 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) Clerk
10b. KIND OF BUSINESS OR INDUSTRY Carter Carburetor
11. BIRTHPLACE (City and state or country) Florissant Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Leon Archambault
13b. MOTHER'S MAIDEN NAME Laura Chappie
14. NAME OF HUSBAND OR WIFE Catherine E. Archambault
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO.
17. INFORMANT Address Catherine Archambault 10361 St. Chas Rd

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) Unknown Natural Causes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ 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.)
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 ____, to ____ and last saw her/him alive on ____
Death occurred at 3:16P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John C. Murphy M.D. John C. Murphy M.D. Asst. Health Commissioner
22b. ADDRESS 801 S. Brentwood Clayton, Mo.
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2)16)1961
23c. NAME OF CEMETERY OR CREMATORY St. Ferdinand Cemetery
23d. LOCATION (City, town, or county) Florissant (State) Mo.

24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo. ADDRESS
25. DATE RECD. BY LOCAL REG. 2-14-61
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | DOCUMENT | SHOULD READ | BY AFFIDAVIT OF | ITEM NO.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Sheldon Collier

Signature of Student Embalmer

Licensed Embalmer No. 3382

P. O. Address St. Ann M

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.