

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

3850-61-015577  
STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

|  |  |   |   |  |   |   |   |
|--|--|---|---|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |   |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>  |  |   |   | Length of stay in 1b   |   | c. CITY OR TOWN <b>ST. LOUIS</b>  |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3550<sup>a</sup> GILES</b>  |  |   |   | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | d. STREET ADDRESS (If outside, give location) <b>3550<sup>a</sup> GILES</b> |   |
| 3. NAME OF DECEASED (Type or print)  |  |   |   | 4. DATE OF DEATH   |   | 5. AGE (last birthday)  |   |
| First <b>SALEM</b> Middle <b>ROMANUS</b> Last  |  |   |   | Month <b>April</b> Day <b>19</b> Year <b>1961</b>  |   | 71  |   |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>   |   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>MAR. 18 1890</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CITY EMPLOYEE</b>   |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country) <b>SYRIA</b>                     |   |
| 13a. FATHER'S NAME <b>UNKNOWN</b>  |  |   |   | 13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>   |   | 14. NAME OF HUSBAND OR WIFE <b>ANNA ROMANUS</b>                             |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>   |  |   |   | 17. INFORMANT <b>FRED ROMANUS AFFTON Mo</b>  |   |   |   |
| 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) <b>arteriosclerotic heart disease</b>  |  |   |   |  |   |   |   |
| DUE TO (b) _____   |  |   |   |  |   |   |   |
| DUE TO (c) <b>4200</b>   |  |   |   |  |   |   |   |
| 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 <b>2-2-47</b> to <b>4-19-67</b> and last saw him alive on <b>4-15-67</b> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |  |   |   |   |
| 22a. SIGNATURE <b>C. F. MERTEN M.D.</b> (Degree or title)  |  |   |   | 22b. ADDRESS <b>3587 Polaner</b>   |   |   | 22c. DATE SIGNED <b>4-21-61</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE <b>APR. 22 1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>S.S. PETER &amp; PAUL</b> |  | 23d. LOCATION (City, town, or county) <b>ST. LOUIS Mo</b> |   | (State)   |
| 25. DATE RECD. BY LOCAL REG. <b>APR 22 1981</b>  |  |   |   | 26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>  |   |   |   |

MEDICAL CERTIFICATION

12-2  
Harvey

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Looney Harper

Licensed Embalmer No. 4861

P. O. Address Clayton 5/10

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.