

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026418

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 149 STATE FILE NUMBER

AMENDED

FILED JUN 28 1961

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST. CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. CHARLES		Length of stay in 1b 18 hours	c. CITY OR TOWN Saint Charles
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 440 Houston
3. NAME OF DECEASED (Type or print) First Middle Last Jerry Jerome Simburger			4. DATE OF DEATH Month Day Year June 20 1961
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 20, 61
9. AGE (last birthday) newborn		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min. 18 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Saint Charles, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Ohren Clement Simburger	
13b. MOTHER'S MAIDEN NAME Connie Marie Bell		14. NAME OF HUSBAND OR WIFE none	
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. none	17. INFORMANT Address Ohren Simburger, St. Charles, MO
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYALINE MEMBRANE DISEASE DUE TO (b) PREMATURITY DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 18 hours
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 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.)	
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 8 AM 6-20-61 to 11:45 PM 6-20-61 and last saw her/him alive on 6-20-61 Death occurred at 11:45 PM 6-20-61 p.m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. E. Hammes M.D.</i> (Degree or title)		22b. ADDRESS 207 N. 5th St., St. Charles, Mo.	22c. DATE SIGNED 6-21-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 23, 1961	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) (State) Saint Charles, Mo.
24. FUNERAL DIRECTOR ADDRESS H.C. Dallmeyer & Sons Co., St. Charles, Mo.		25. DATE RECD. BY LOCAL REG. JUNE 22-61	26. REGISTRAR'S SIGNATURE <i>Marcella Wilson</i>

Note

Body not embalmed

STATEMENT BY LICENSED EMBALMER

Franc Amalan
4832

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.