

318

1003

9812

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED

FILED NOV 8 1961

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b Life | c. CITY OR TOWN St. Louis |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6055 Oleatha Ave Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Paul NMN Girard | | | 4. DATE OF DEATH Month Day Year October 22 1961 | | |
|---|--|--|---|--|--|

| | | | | | | |
|----------------|---------------------------|---|----------------------------|------------------------------|---|------------------------------|
| 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 5/1/77 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months Days Hours Min. 5 21 | IF UNDER 24 HR Hours Min. |
|----------------|---------------------------|---|----------------------------|------------------------------|---|------------------------------|

| | | | |
|--|---|---|---------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Sgt. Retired | 10b. KIND OF BUSINESS OR INDUSTRY St. Louis Police Dept. | 11. BIRTHPLACE (City and state or country) St. Louis | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
|--|---|---|---------------------------------------|

| | | |
|--------------------------------------|--------------------------------------|--|
| 13a. FATHER'S NAME Unknown Girard | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Elizabeth Girard Deceased |
|--------------------------------------|--------------------------------------|--|

| | | |
|--|-------------------------|---|
| 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. | 17. INFORMANT Address William Girard 6055 Oleatha 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) <i>Broncho Pneumonia</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | <i>491X</i> |

| | |
|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerotic Heart Disease, Cerebral Arteriosclerosis, Emphysema</i> | 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 *8/21/61* to *10-20-61* and last saw ^(him) alive on *10-20-61*
Death occurred at *4:45 P.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|--|-------------------------------------|
| 22a. SIGNATURE (Degree or title) <i>Joseph V. Donnell M.D.</i> | 22b. ADDRESS <i>539 N. Grand St. St. Louis 3, Mo.</i> | 22c. DATE SIGNED <i>10/23/61</i> |
|---|--|-------------------------------------|

| | | | |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE <i>10/25/61</i> | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park | 23d. LOCATION (City, town, or county) (State) St. Louis County Mo. |
|--|------------------------------|---|---|

| | | | |
|---|---------------------------|---|--|
| 24. FUNERAL DIRECTOR C. Hoffmeister Mortuary | ADDRESS 6464 Chippewa. | 25. DATE RECD. BY LOCAL REG. OCT 24 1961 | 26. REGISTRAR'S SIGNATURE <i>Roan Smith. M.D.</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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Rice C. Branson

Licensed Embalmer No. 4764

P. O. Address St Louis Mo

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.