

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

STATE AMENDED

INSTEAD OF

DOCUMENT

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9394 STATE FILE NUMBER =61-038649

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>4 mo.</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1485 Laurel</u>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle Last <u>Hale</u>	4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>61</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-87</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Emanuel Hale</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Cowen</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>Chronic Hospital Records</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS - BRACHOPNEUMONIA</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c) <u>491x</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES - DECUBITI (LARGE AND INFECTED)</u>	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
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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.)
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20c. TIME OF INJURY Hour <u>1:00</u> a.m. p.m. Month, Day, Year <u>5-29-61</u>
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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 <u>St. Louis, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from 5-29-61 to 9-24-61 and last saw her/him alive on 9-24-61
Death occurred at 1:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John J. Kearney M.D.</u>	(Degree or title)	22b. ADDRESS <u>5800 Arsenal Ave</u>	22c. DATE SIGNED <u>9-25-61</u>
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23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Bowland-Aker Mortuary Service</u>	23b. DATE <u>OCT 31 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>	(State)
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24. FUNERAL DIRECTOR'S ADDRESS <u>4904 Manchester Ave, St. Louis 10, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 11 1961</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, II. V.</u>
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ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 _____

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.