

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

10089

-61-039040

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10089 STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

VIEWING SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		17. ADDRESS	
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)		7 days	
DUE TO (b)		4 years	
DUE TO (c)		15 years	
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.	
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"/>	
20c. TIME OF INJURY		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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		and last saw him alive on	
Death occurred at		m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title)		22b. ADDRESS	
22c. DATE SIGNED		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)	
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	
26. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE	

FILED NOV 8 1961

St. Louis, Mo.

Sappington, Mo.

9410 Parklind Dr.

Irene Oppliger

Oct. 30, 1961

female white

Feb. 1, 1892

none at home St. Louis, Mo. USA

Oliver Fath Emma Von Gerichten Fred P. Oppliger

no no no Fred P. Oppliger 9410 Parklind Dr.

cerebral hemorrhage

Hypertensive cardiovascular disease

Diabetes mellitus

Jaenness cirrhosis of liver; arteriosclerotic heart disease

260X

13 March 57, to 30 Oct 61 and last saw him alive on 30 Oct 61

4 p.m.

James F. Michel, M.D.

#52 Maryland Plaza St Louis 8, Mo.

31 Oct 61

entombment 10-31-61 Calvary Cem. St. Louis, Mo.

Southern Funeral Home 6322 S. Grand, St. Louis, Mo.

OCT 31 1961

Loan Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

David Van Fossan

Licensed Embalmer No. 4343

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.