

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004711

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 65

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4003

2 40052

3

4 0

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11 1244-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JAN 25 1963						
1. PLACE OF DEATH						
a. COUNTY <u>St. Louis</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood, Mo.</u>	a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>					
Length of stay in 1b <u>2 Days</u>	c. CITY OR TOWN <u>Richmond Heights</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>	d. STREET ADDRESS (If outside, give location) <u>1200 Sunset Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>S.</u> Last <u>URE</u>	4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1963</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1893</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u>	IF UNDER 24 HR. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Solomon M. Ure</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Bradley</u>	14. NAME OF HUSBAND OR WIFE <u>Ruby Ure</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of serv. <u>World War I</u>)	16. SOCIAL SECURITY NO. <u>[Redacted]</u>	17. INFORMANT Address <u>Martha Jane Sinclair 1200 Sunset Av.</u>				
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 Days</u>				
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Coronary Heart Disease</u>		<u>5</u>				
DUE TO (c) <u></u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary embolism & infarction</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				
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 <u></u> a.m. <u></u> p.m. <u></u>	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 <u>May 15 59</u> to <u>Jan 7 63</u> and last saw him alive on <u>Jan 7 63</u> Death occurred at: <u>5:20 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Karl F. Kessler M.D.</u>	22b. ADDRESS <u>1139 Bellevue Ave.</u>	22c. DATE SIGNED <u>Jan 8-63</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 9, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>				
23d. LOCATION (City, town, or county) <u>St. Louis</u>		Mo. <u></u>				
24. FUNERAL DIRECTOR ADDRESS <u>A. H. Bocklage 6536 Clayton Rd.</u>	25. DATE RECD. BY LOCAL REG. <u>1-8-1963</u>	26. REGISTRAR'S SIGNATURE <u>J. M. Murphy M.D.</u>				

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 Elton H. Remelius

Licensed Embalmer No. 4283

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.