

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033957

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8851** STATE FILE NUMBER

FILED SEP 6 1963

VS 300
Rev. 4/59

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DATE AMENDED

10-2-63
10-2-63
8-29-1988
75

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

10-2-63

10-2-63

8-23-1986

BY AFFIDAVIT OF *inferment* DOCUMENT *Monday State of Ill. 8-23-1988* MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Granite City	
Length of stay in 1b 2 WEEKS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 2548 Cleveland	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Chester W. Munson			4. DATE OF DEATH Month Day Year Sept. 1 1963		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-23-1888	9. AGE (last birthday) 75	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY MACHANICAL ENGINEER		11. BIRTHPLACE (City and state or country) MORRIS, ILL. U.S.A.	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME J. A. MUNSON		13b. MOTHER'S MAIDEN NAME ALAIWA WALKER	
14. NAME OF HUSBAND OR WIFE MARY MUNSON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. MARY MUNSON	
17. INFORMANT MARY MUNSON		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		Address 2548 CLEVELAND GRANITE CITY, ILL.	

IMMEDIATE CAUSE (a) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Carcinoma of right maxillary sinus sev. years	
DUE TO (c) 160.2			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Radical neck dissection 8/19/63		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.)	
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 **August 18, 1963** to **Sept. 1, 1963** and last saw her alive on **Sept. 1, 1963**
Death occurred at **8:03 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Franklin V. Hoffmeyer

22b. ADDRESS **BARNES HOSPITAL**

22c. DATE SIGNED **9/2/63**

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-3-63	23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE CEMETERY	23d. LOCATION (City, town, or county) (State) CHAMPAIGN, ILLINOIS
24. FUNERAL DIRECTOR MERCER FUNERAL HOME		ADDRESS ILLINOIS	
DATE RECD. BY LOCAL REG. SEP 3 1963		REGISTRAR'S SIGNATURE <i>Coal Smith. M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

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

Charles E. Mercer

Licensed Embalmer No.

2988

P. O. Address

Hamite City, Ill

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.