

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037485

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9310 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

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FILED SEP 27 1963

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>2 wks</u>	c. CITY OR TOWN <u>Overland</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. Lukes Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9010 Lackland Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Dennison</u> Last <u>Dennison</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1963</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>11-1-1897</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Wkr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stairwall Elec.</u>		11. BIRTHPLACE (City and state or country) <u>Candle England</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ernest Dennison</u>			13b. MOTHER'S MAIDEN NAME <u>Polly Ducksberry</u>		14. NAME OF HUSBAND OR WIFE <u>Willa Dennison</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW #1</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Overland 14</u> <u>Willa Dennison-9010 Lackland Rd.</u>	
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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:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral aneurysm post operation</u>			<u>36 hr</u>
DUE TO (b) <u>Adeno carcinoma of colon</u>			<u>6 ad.</u>
DUE TO (c) <u>153.8</u>			
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. <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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <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 7-1-63 to 9-15-63 and last saw her/him alive on 9-15-63
 Death occurred at 2:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>9440 Midland Overland 14, Mo.</u>	22c. DATE SIGNED <u>9-16-63</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-19-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Pagedale, Mo.</u>
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24. FUNERAL DIRECTOR <u>Baumann Bros, Inc.</u> ADDRESS <u>2504 Woodson Rd., Overland 14, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 17 1963</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF
 DOCUMENT
 MEDICAL CERTIFICATION
 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 David B Gibson

Licensed Embalmer No. 3454

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.