

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041341

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10994

STATE FILE NUMBER

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT	DATE AMENDED
Rev. 4/59		
1		
2 <u>209</u>		
3		
4 <u>0</u>		
5 <u>0</u>		
6		
7 <u>1</u>		
8 <u>2</u>		
9		
10		
11		
12 <u>80-0</u>		
13		
<u>80</u>	ITEM NO.	SHOULD READ
	BY AFFIDAVIT OF	

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in lb <u>34 yrs</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. Louis State Hospital</u>		d. STREET ADDRESS (if outside, give location) <u>207 Douglas St.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED			4. DATE OF DEATH
First <u>Virgil</u> Middle <u>Dale</u> Last			Month <u>October</u> Day <u>31</u> Year <u>1963</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-7-94</u>	
Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		9. AGE (last birthday) <u>69 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John W. Dale</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Rettinger</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>St. Louis State Hospital Records</u>	
Address		Address	
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>Myocardial Infarction</u>			
DUE TO (b) <u>Stoke-Adams Syndrome</u>			
DUE TO (c) <u>4201</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Schizophrenia</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 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.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from <u>November 4, 1929</u> to <u>October 31, 1963</u> and last saw her/him alive on <u>October 31, 1963</u>			
Death occurred at <u>4:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>5100 Arsenal St.</u>	
22c. DATE SIGNED <u>11-1-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11-30-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
24. FUNERAL DIRECTOR <u>MO. ANATOMICAL BOARD, 1402 S. GRAND</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 7 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Road Smith, 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 _____

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.