

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046317

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3575

FILED DEC 16 1963

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton MO</u> Length of stay in 1b <u>6 DYS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County H.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis County</u> c. CITY OR TOWN <u>Oakland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>719 E. Madison</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>CALVIN</u> Middle <u>CURRY</u> Last <u>CURRY</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col.</u> 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baldwin MO</u>			4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1963</u> 9. AGE (last birthday) <u>84</u> 11. BIRTHPLACE (City and state or country) <u>Baldwin MO</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>		
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13a. FATHER'S NAME <u>John Curry</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u> 16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	14. NAME OF HUSBAND OR WIFE <u>Emily Curry</u> Address <u>719 E. Madison</u> 17. INFORMANT <u>Emily Curry</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: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia</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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 11-7-63 to 11-13-63 and last saw her/him alive on 11-13-63
 Death occurred at 1:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John M. Jarner, M.D.</u>	22b. ADDRESS <u>601 S. Brentwood Blvd., Clayton</u>	22c. DATE SIGNED <u>11-18-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-18-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson</u>	23d. LOCATION (City, town, or county) (State) <u>Crestwood MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>JOHN W. HEMPHILL 408 S. Fillmore</u>	25. DATE RECD. BY LOCAL REG. <u>11-18-63</u>	26. REGISTRAR'S SIGNATURE <u>John W. Hemphill</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 1 4002
 2 4000
 3 2
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 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

Thelma E. Cooper

Licensed Embalmer No. 4600

P. O. Address 4648 St. Ferdinand

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.