I DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 3 1960

60-009309
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 538

1. PLACE OF DEATH a. COUNTY: St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo. b. COUNTY: St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Normandy	Length of stay in 1b: 28 Yrs.	c. CITY OR TOWN: Normandy	Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 8545 Geiger Road	Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location): 8545 Geiger Road	Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Henry	W.	Dale	2	15	1960

5. SEX	6. COLOR OR RACE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HR Hours / Min.
Male	White		1/12/91	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Carpenter (ret.)	Carpenter	St. Louis, Mo.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
William Dale	Kate -	Alice Dale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	492-09-6350	Mrs. Alice Dale, 8545 Geiger Rd.

MEDICAL CERTIFICATION

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)	Coronary Occlusion Aortic	Minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cor Pulmonal	
DUE TO (c)	Asthma, Bronchial, Chronic	over 10 yrs

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	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 ☐ NOT WHILE AT WORK ☐	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 18 Sept 57 to 15 Feb 60 and last saw him alive on 5 Feb 60

Death occurred at 15 Feb 60 3 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
[signature] M.D.	1160 So. Florissant Rd	16 Feb 60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
removal	2/18/60	Calvary Cemetery	St. Louis Mo.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Drehmann-Harral, 1905 Union Blvd.	2-17-60	John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Warren A. Carr

Signature of Student Embalmer

Licensed Embalmer No. 953

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.