

ISSUED DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004207

FILED VS JAN 19 1961

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 56

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch, Missouri</b>		Length of stay in 1b <b>303 days</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3625 Castleman Avenue.,</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>F.</b> Last <b>NOVELL</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>6</b> Year <b>1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6-10-76</b>		9. AGE (last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Dairyman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Swiss Model Dairy</b>		11. BIRTHPLACE (City and state or country) <b>Kentucky, Columbus</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>J.J. Novell</b>				13b. MOTHER'S MAIDEN NAME <b>Ella Coffee</b>				14. NAME OF HUSBAND OR WIFE <b>Fannie Novell(deceased)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>????</b>		17. INFORMANT Address <b>Records at Koch Hospital, Koch, Mo</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>??</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <b>Generalized Arteriosclerosis</b>							<b>11</b>			
			DUE TO (c) <b>Senile Obstructive Emphysema</b>							<b>420.0 F ??</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>I.T. Fx of Left Hip; Cholecystectomy, Colostomy</b>								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.) <b>Pt fell at home Jan 1960</b>									
20c. TIME OF INJURY Hour s.m. p.m. <b>Jan 1960</b>													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>			20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>		COUNTY		STATE				
21. I attended the deceased from <b>3-9-60</b> to <b>Jan 6th, 1961</b> and last saw her/him alive on <b>1-6-61</b> Death occurred at <b>4:10 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Deceased or title) <i>David Russell</i> <b>M.D.</b>				22b. ADDRESS <b>Koch Hospital, Koch Mo</b>				22c. DATE SIGNED <b>1-6-61</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1/7/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Home of Aged Baptist Cemetery</b>		23d. LOCATION (City, town, or county) <b>Inonton, Missouri</b>		(State)					
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.,</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1-6-61</b>		26. REGISTRAR'S SIGNATURE <i>John B. Manly</i>					

**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 R. Sadwell

Licensed Embalmer No. 4097

P. O. Address St. Louis

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.