

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027585

STATE FILE NUMBER

318

1003

Registrator's 2001

FILED JUL 28 1958

Registration District No.

Primary Registration District No.

Registrator's 2001

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN 2627 BROUSTER		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DE PAUL HOSP.			Length of stay in 1b 30 DAYS		d. STREET ADDRESS MID-WIND		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last AFFIE AMANDA WILMURTH				4. DATE OF DEATH Month Day Year 7-14-58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-28-1873		9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) HICKMAN CO KY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CARTER				14. MOTHER'S MAIDEN NAME AMANDA CRUTCHFIELD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address 2627 PINKIE GARDNER BROUSTER			
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>Cerebral Vascular Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> 331A DUE TO (c) <u>ASHD - Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anterior Myocardial Infarction Pulmonary Embolism</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
19a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Hour a. m. p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
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 <u>7/10/58</u> to <u>7/14/58</u> and last saw her ^{her} alive on <u>7/13/58</u> Death occurred at <u>12:30</u> <u>Am</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Franklin P. ...</u> (Degree or title)				22b. ADDRESS <u>10011 Bellefontaine Rd.</u>		22c. DATE SIGNED <u>7/10/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 7-15-58	23c. NAME OF CEMETERY OR CREMATORY OAK WOOD CEMETERY		23d. LOCATION (City, town, or county) (State) CHINTON KENTUCKY		
24. FUNERAL DIRECTOR EARL HILMAN 9709 BACKLAND, OVERLAND MO				25. DATE RECD. BY LOCAL REG. JUL 15 58		26. REGISTRAR'S SIGNATURE <u>Earl Smith MO</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare
Public Service

S. 300
7. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Carl J. Hillen*

Licensed Embalmer No. *300*

P. O. Address *Greider 14*

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.