

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH															
FILED VS FEB 1 1961				318				1003				627			
Registration District No.				Primary Registration District No.				Registrar's No.				STATE FILE NUMBER			
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>				Length of stay in 1b		c. CITY OR TOWN <b>New Haven</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>Deaconess Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>- -</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Mavis</b> Middle <b>Virginia</b> Last <b>Diggs</b>						4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1961</b>									
5. SEX <b>Female</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>9/25/1861</b>		9. AGE (last birthday) <b>99</b>		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Washington, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>							
13a. FATHER'S NAME <b>Benjamin Burch</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>Thomas P. Diggs</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>None</b>		17. INFORMANT <b>Mary Diggs, New Haven, 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>Coronary artery disease</b> <b>arteriosclerosis of the heart</b> DUE TO (b) <b>arteriosclerosis, generalized</b> DUE TO (c) <b>Secondary to fracture hip left</b>										INTERVAL BETWEEN ONSET AND DEATH <b>420.0F</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1-23-61 Fracture hip left</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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>Fell out of Bed at Deaconess Hospital while a patient in Hospital.</b>											
20c. TIME OF INJURY Hour a.m. p.m. <b>1/18/61</b>		Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>at Deaconess Hospital</b>						20f. CITY, TOWN, OR LOCATION <b>St. Louis, Missouri.</b>		COUNTY STATE			
21. I attended the deceased from <b>1/16/61</b> to <b>1/19/61</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>1/19/61</b> Death occurred at <b>8:45 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <b>Donald O. Burst M.D.</b>						22b. ADDRESS <b>6500 Chippewa Street.,</b>				22c. DATE SIGNED <b>1/20/61</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-20-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Haven, Mo.</b>		23d. LOCATION (City, town, or county) (State)									
24. FUNERAL DIRECTOR <b>Fertig Funeral Home, New Haven, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 21 1961</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b>									

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 J W Dinkley

Licensed Embalmer No. 2653

P. O. Address St Louis 8 Mo

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.