

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007068

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 566

AMENDED FILED VS MAR 2 1961

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF  
ITEM NO.

|   |   |   |   |   |  |  |
|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. LOUIS</b>   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>AFTON</b>  |   | Length of stay in 1b <b>1 DAY</b>   | c. CITY OR TOWN <b>ARCADIA</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   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <b>BOX 141</b>  |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>RUTH E. ATCHISON</b>  |   |   | 4. DATE OF DEATH Month Day Year<br><b>FEBRUARY 26, 1961</b>   |   |  |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>CAUCASIAN</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>8/1/1899</b>                                      | 9. AGE (last birthday) <b>61</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>HOUSEWIFE</b>  | 10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  | 11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b> |  | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>   |
| 13a. FATHER'S NAME <b>WARD CALVERT</b>  |   | 13b. MOTHER'S MAIDEN NAME <b>MARGARET FALL</b>  |   | 14. NAME OF HUSBAND OR WIFE <b>HOMER N. ATCHISON</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.   | 17. INFORMANT <b>HOMER N. ATCHISON</b>  |   | Address <b>SEE #2</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of Pancreas</b><br><b>obstructive jaundice</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hemorrhage</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 wks</b><br><b>1 day</b>                   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)  |   |   |  |  |
| 20c. TIME OF INJURY Hour 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 <b>2/7/61</b> to <b>2/26/61</b> and last saw her/him alive on <b>2-25-61</b><br>Death occurred at <b>9:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |   |   |  |  |
| 22a. SIGNATURE <b>J. Thompson MD</b> (Degree or title)  |   |   | 22b. ADDRESS <b>52 Maywood Plaza</b>  |   | 22c. DATE SIGNED <b>2/27/61</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City, town, or county) (State)                         |  |  |
| <b>BURIAL</b>   | <b>3/1/1961</b>   | <b>SUNSET BURIAL PARK</b>   |   | <b>ST. LOUIS COUNTY, MISSOURI</b>                                     |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>HOFFMEISTER COLONIAL MORTUARY</b><br><b>6464 CHIPPEWA STREET ST. LOUIS (90)</b>   |   |   | 25. DATE RECD. BY LOCAL REG. <b>2-27-61</b>   | 26. REGISTRAR'S SIGNATURE <b>John C. Murphy MD</b>                    |  |  |

**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 *Eric C. Shannon*

Licensed Embalmer No. 4764

P. O. Address St Louis 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.