

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2245 STATE FILE NUMBER

FILED VS MAR 16 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>			Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) <u>D.O.A.</u> HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4943 Buckingham Ct.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>NMN</u> Last <u>Alexander</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1961</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/1888</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 1 YEAR Hours	IF UNDER 24 HR Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Head Social Service Exchange</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Carrollton, Mo</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Robert S. Alexander</u>			13b. MOTHER'S MAIDEN NAME <u>Ada Tull</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Marshall, Mo</u> <u>Mr Pete Rea 522 No. Brunswick</u>				
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>Fractured neck, with Hemorrhage; suffered when car operated by deceased was struck by car operated by one Albert Lucas in front of about 5925 Page, about 2:45 pm, on March 5, 1961.</u> DUE TO (b) <u>Crucial carelessness on part of Albert Lucas.</u> DUE TO (c) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH		
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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.) <u>See above</u>					
20c. TIME OF INJURY Hour <u>2:45</u> a.m. / p.m. Month, Day, Year <u>3-5-61</u>		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.) <u>06 street</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis, Mo.</u>		COUNTY	STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>315 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Joseph M. J. Smith, M.D.</u>				22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>3-7-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)		
<u>Removal Rail</u>		<u>3/8/61</u>	<u>Carrollton, Missouri</u>		<u>Carrollton, Missouri</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Alexander & Sons 6175 Delmar Blvd</u>				25. DATE RECD. BY LOCAL REG. <u>MAR 7 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loaf Smith, M.D.</u>			

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 Joseph E. McEnish

Licensed Embalmer No. 27620

P. O. Address 6120 R. Alma

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.