SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-~~[illegible]~~

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2367 STATE FILE NUMBER 10562

FILED MAR 23 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 5390 Pershing Avenue., — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MAUDE Middle F. Last CASE
4. DATE OF DEATH: Month MARCH Day 10 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6/12/1889
9. AGE (last birthday): 71
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Hamburg, Arkansas.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: John L. Foote
13b. MOTHER'S MAIDEN NAME: Felecia Willis
14. NAME OF HUSBAND OR WIFE: John H. Case
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): Nil
16. SOCIAL SECURITY NO.:
17. INFORMANT: John H. Case, 5390 Pershing Avenue., Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): MALNUTRITION AND SENILITY
DUE TO (c): 286.5
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. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 JAN. 14, 1944, to MARCH 10, 1961 and last saw her/him alive on MARCH 10, 1961
Death occurred at 1:25 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: FR Bradley (Degree or title): F. R. BRADLEY, M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 3/10/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3/12/61
23c. NAME OF CEMETERY OR CREMATORY: Local Cemetery
23d. LOCATION (City, town, or county) (State): Hamburg, Arkansas.
24. FUNERAL DIRECTOR: Albert H. Hoppe, Inc. ADDRESS: 4708 Washington Blvd.,
25. DATE RECD. BY LOCAL REG.: MAR 10 1961
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

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

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 Elton R. H. Remelius

Licensed Embalmer No. 4283

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.