

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

2190

61-011501

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

AMENDED

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>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2426 S. 3rd ST</u>		d. STREET ADDRESS (If outside, give location) <u>2426 S. 3rd ST.</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK SANCHEZ</u>			4. DATE OF DEATH Month Day Year <u>MARCH 4 1961</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 4. 1864</u>	9. AGE (last birthday) <u>96</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MEXICO</u>	12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>	
13a. FATHER'S NAME <u>FRANK SANCHEZ</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>JULIA SANCHEZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>RAMONA WESLEY 2426 S. 3rd ST.</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>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
DUE TO (b) <u>Generalized Arteriosclerosis</u>			
DUE TO (c) <u>420-0</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Thrombophlebitis left leg</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. 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
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21. I attended the deceased from <u>March 1960</u> to <u>3/4/61</u> and last saw her/him alive on <u>3/4/61</u> Death occurred at <u>5:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Aaron Hendrix MD</u>	22b. ADDRESS <u>4268 Delor</u>	22c. DATE SIGNED <u>3/4/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAR. 6. 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Thomas Katis 2906 Grovois</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 6 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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

Eleanor Province

Licensed Embalmer No.

3403

P. O. Address

2906 Graves

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.