

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

APR 10 1961

61-012197

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 801

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give township) OR TOWN ST LOUIS COUNTY DAYS		c. CITY OR TOWN ST LOUIS COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION COUNTY HOSPITAL		d. STREET ADDRESS (If outside, give location) 8249 IRVINGTON	
3. NAME OF DECEASED (Type or print) First Middle Last SUSIE YATES		4. DATE OF DEATH Month Day Year 3 22 61	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-9-1906
9. AGE (last birthday) 60		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) NIL		10b. KIND OF BUSINESS OR INDUSTRY NIL	11. BIRTHPLACE (City and state or country) MISS U.S.A
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME ALBERT WILLIAM	
13b. MOTHER'S MAIDEN NAME SUSON HALL		14. NAME OF HUSBAND OR WIFE unkn-	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MATTIE WILLIAM		Address IRVINGTON 8249	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown natural causes			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) _____			
DUE TO (c) _____			
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 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
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 February 18, 1961 to March 22, '61 and last saw her alive on March 22, 1961 Death occurred at 5:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) Robert L. Howe MD		22b. ADDRESS 601 S. Brentwood Bl.	22c. DATE SIGNED 3/22/61
23a. BURIAL, CREMATION, REMOVAL, etc. GREENWOOD	23b. DATE 3-27-61	23c. NAME OF CEMETERY OR CREMATORY GREENWOOD	23d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY MO
24. FUNERAL DIRECTOR SIMAN-MEBHEE UND. CO		25. DATE RECD. BY LOCAL REG. 3-24-61	26. REGISTRAR'S SIGNATURE John C. Manly M.D.
ADDRESS 1619 N. UNION			

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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.