

AMENDED
 DATE AMENDED 5/22
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR ST. LOUIS, MISSOURI			Length of stay in 1b 86 DAYS	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 NO. GRAND AVE.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5560 CATES		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER H. FLOYD				4. DATE OF DEATH Month Day Year 4/28/61			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5/2/20	9. AGE (last birthday) 40	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) CHIEF			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) HENDERSON, KENTUCKY	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME SAMUEL FLOYD			13b. MOTHER'S MAIDEN NAME JOHNSON IDELLA JOHNSON		14. NAME OF HUSBAND OR WIFE ROSE FLOYD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-II				17. INFORMANT Address ROSE FLOYD (WIFE) SEE #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE AND HYPERTENSIVE CARDIOVASCULAR DISEASE	
						DUE TO (c) POLYCYSTIC KIDNEYS	
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 type="checkbox"/> No <input type="checkbox"/> Unknown 757-1		
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.) 757-1			
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	
21. I attended the deceased from 2/1/61 to 4/28/61 and last saw him ^{BEFORE} alive on 4/28/61 Death occurred at 7:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) DUANE E. COZART, M.D.				22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 4/28/61	
23a. BURIAL, CREMATION, REMOVAL, etc. Shipping	23b. DATE 4/29/61	23c. NAME OF CEMETERY OR CREMATORY Gaines Funeral Home		23d. LOCATION (City, town, or county) (State) Evansville, Indiana			
24. FUNERAL DIRECTOR E. B. Keane			ADDRESS 1221 North Grand	25. DATE RECD. BY LOCAL REG. APR 29 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		

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 *Malina Blarshorn*
Licensed Embalmer No. 3962

P. O. Address _____

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.