

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-015835

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 989

FILED APR 17 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in 1b <u>1 Week</u>	c. CITY OR TOWN <u>Overland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8146 Vena Ave</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8915 Windom Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Cain</u> Last <u>Cain</u>			4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-76</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Pana, Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Einig</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Jobst</u>		14. NAME OF HUSBAND OR WIFE <u>John Cain Dec.</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>Joseph Einig 8146 Vena Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>						
DUE TO (b) <u>Cerebral Thrombosis</u>						
DUE TO (c) <u>Generalized Arteriosclerosis</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive Heart Failure</u>					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 <u> </u> a.m. <u> </u> 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 <u>April 3, 1961</u> to <u>present</u> and last saw her/him alive on <u>April 3, 1961</u> Death occurred at <u>approx 5 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Arthur H. Gearhart M.D.</u>			22b. ADDRESS <u>8711 St. Charles Rd.</u>		22c. DATE SIGNED <u>4/10/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-12-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>J.W. Clark F.H. 1125 Hodiamont</u>			25. DATE RECD. BY LOCAL REG. <u>4-11-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Alfred J. Boedeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hudson

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.

Dr. Gearhart

8711 St. Chas. Rk Rd.