

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-019021  
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5166  
FILED JUN 8 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. # 1</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1704 Lafayette</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LYDIA</b> Middle <b>COUPLLE</b> Last			4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/14/80</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Unknown</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Willis Scott</b>		13b. MOTHER'S MAIDEN NAME <b>Suda - Unk.</b>		14. NAME OF HUSBAND OR WIFE <b>Unk.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Hosp Med. Record Dept</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Blood Loss</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Hemorrhagic Cystitis</b>			
		DUE TO (c) <b>Pyelonephritis</b> <b>600.0</b>			
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>5/18/61 9:30 a.m.</b> to <b>5/19/61</b> and last saw her <input type="checkbox"/> alive on <b>5/19/61</b> Death occurred at <b>1:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>John McFarough M.D.</i> (Degree or title)			22b. ADDRESS <b>1515 Lafayette Ave.</b>		22c. DATE SIGNED <b>5/20/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6/2/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Dale</b>		23d. LOCATION (City, town, or county) (State) <b>Lemay, Mo.</b>
24. FUNERAL DIRECTOR <b>Cunningham &amp; Moore, 2405 Marcus</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>JUN 2 1961</b>		26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>	

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 John K. Cunningham  
Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.