

318 Primary Registration District No. 1003 Registrar's No.

Registration District No. FILED AUG 31 1961

AMENDED

| | | | | | |
|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 1 yr. | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp. | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1709 Pendleton | |
| 3. NAME OF DECEASED (Type or print) First Middle Last George Alexander | | | 4. DATE OF DEATH Month Day Year 8-15-61 | | |
| 5. SEX Male | 6. COLOR OR RACE Col. | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1891 | 9. AGE (last birthday) 70 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Sep. | 11. BIRTHPLACE (City and state or country) Ky. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk. | | 16. SOCIAL SECURITY NO. Unk. | 17. INFORMANT Address St. Louis State Hospital 5400 Arsenal | | |
| 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) Congestive Heart Failure | | | | | 12 hrs |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary artery Disease | | | | | 8 yrs |
| DUE TO (c) 420.1B | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Meningo vascular syphilis | | | | | 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 |
| 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.) | |
| 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 6-27-60 to 8-15-61 and last saw her/him alive on 8-15-61 Death occurred at 9:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Kenneth C. Rice M.D. | | | 22b. ADDRESS 5600 Arsenal | | 22c. DATE SIGNED 8-14-61 |
| 23a. BURIAL, CREMATION, OR MORTUARY SERVICE Rohland Mortuary Services 4104 Manchester Ave. St. Louis 10, Mo. | 23b. NAME OF CEMETERY OR CREMATORY 3-21-1961 Anatomical Board | | 23c. LOCATION (City, town, or county) (State) St. Louis, Mo. | | |
| 24. FUNERAL DIRECTOR'S ADDRESS St. Louis 10, Mo. | | 25. DATE RECD. BY LOCAL REG. AUG. 24 1961 | | 26. REGISTRAR'S SIGNATURE Roan Smith. M.D. | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

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 _____

Licensed Embalmer No. _____

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.