

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-035224
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2793

AMENDED

FILED OCT 9 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Affton</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>1 Week</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>7081 Whitworth</u>		d. STREET ADDRESS (If outside, give location) <u>8522 Titchfield Ct.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>COOK</u> Last <u>COOK</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1961</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>7-5-1898</u>
9. AGE (last birthday) <u>63</u>		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) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (City and state or country) <u>Pittsburgh, Penn.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Francis Allen</u>	
13b. MOTHER'S MAIDEN NAME <u>Laura Wyland</u>		14. NAME OF HUSBAND OR WIFE <u>Late Ben Cook</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 <u>Edith Roberts</u>		Address <u>8522 Titchfield Ct.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of Myocardium</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u> <u>UNKNOWN</u>
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 _____ 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 <u>2-21-61</u> to <u>1 Oct 61</u> and last saw her <u>alive</u> on <u>8-15-61</u> Death occurred at <u>11:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>John F. McLean MD</u>		22b. ADDRESS <u>4401 Hampton</u>	22c. DATE SIGNED <u>2 Oct 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Rail)</u>	23b. DATE <u>10-4-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local -Muncie, Ind.</u>	23d. LOCATION (City, town, or county) (State) <u>Muncie, Ind.</u>
24. FUNERAL DIRECTOR <u>Kriegshauser</u>		25. DATE RECD. BY LOCAL REG. <u>10-3-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Amurphy</u>
ADDRESS <u>4228 S. Kingshighway Blvd.</u>			

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 William B White

Licensed Embalmer No. 4291

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.