

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED NOV 10 1961
 Registration District No. 318

Primary Registration District No. 1003 Registrar's No.

9902-51-039158
 STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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 TOWN St. Louis		Length of stay in lb 39 yrs		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 Homer G. Phillips Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4033 Greer Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Maud Royster				4. DATE OF DEATH Month Day Year 10 24 61			
5. SEX Female		6. COLOR OR RACE Negro		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-3-95	
9. AGE (last birthday) 65		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) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Newtown, Miss.	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME Patrick Rickerson			13b. MOTHER'S MAIDEN NAME Ann Politte			14. NAME OF HUSBAND OR WIFE nil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				17. INFORMANT Address Florine Washington 4033 Greer Ave.			
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>Fracture of right hip - generalized</u> DUE TO (b) <u>arterio sclerosis; suffered in fall from bed</u> DUE TO (c) <u>in home on October 15, 1961</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) <u>Acc 102-0-21</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 SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>See above</u>			
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 checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 10 Home		20f. CITY, TOWN, OR LOCATION COUNTY STATE St Louis Mo	
21. I attended the deceased from _____ to _____ and last saw her him alive on _____ Death occurred at <u>10-24-61 12:43A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Helen L. Taylor, Coroner</u>				22b. ADDRESS <u>1300 Clark Ave.</u>		22c. DATE SIGNED <u>10-26-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-27-61		23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR ADDRESS Dement & Son 2629-31 Cole Street				25. DATE RECD. BY LOCAL REG. OCT 26 1961		26. REGISTRAR'S SIGNATURE <u>Neal Smith, M.D.</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 *H. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *1123 N. Taylor*

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.