SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-039444 STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2762

FILED OCT 26 1961

DATE AMENDED 9/2

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO. — Length of stay in 1b 130 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMIN. HOSPITAL — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 803½ CHESTNUT — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First JOHN Middle P. Last BETTS

4. DATE OF DEATH Month 9 Day 30 Year 61

5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 6-3-93
9. AGE (last birthday) 68 YEARS — 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) SAILOR
10b. KIND OF BUSINESS OR INDUSTRY ARMED SERVICES
11. BIRTHPLACE (City and state or country) BROKEN BOW, NEBRASKA
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JOHN M. BETTS
13b. MOTHER'S MAIDEN NAME ANNA SMALL
14. NAME OF HUSBAND OR WIFE NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES — (If yes, give war or dates of service) WW-I & WW-II
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Ruth Seely (Sister) Address 544 S. 25th Str., Omaha, Nebraska

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CASEOUS TUBERCULOSIS, ENTIRE LEFT LUNG — INTERVAL BETWEEN ONSET AND DEATH INDET.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) TRACHEOBRONCHITIS, SEVERE
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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/VA attended the deceased from 5-23-61, to 9-30-61 XXXXXXXXXXXX
Death occurred at 6:00 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul G. Stromsdorfer M.D. PAUL G. STROMSDORFER
22b. ADDRESS VET.ADM.HOSP., JEFF.BRKS., MO.
22c. DATE SIGNED 10-1-61

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE 10/2/61
23c. NAME OF CEMETERY OR CREMATORY Omaha, Neb.
23d. LOCATION (City, town, or county) (State) Omaha, Neb.

24. FUNERAL DIRECTOR Edward Fendler ADDRESS 5611 South Grand Blvd.
25. DATE RECD. BY LOCAL REG. 10-2-61
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Leo J Budde

Licensed Embalmer No. 3989

P. O. Address St Louis Mo

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.