

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042198

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

11354

FILED DEC 12 1961

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		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 LITTLE FLOWER CONV. HOME			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1866 MENARD ST		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First FRONIE Middle BEDFORD Last MOORE				4. DATE OF DEATH Month DEC Day 3 Year 1961									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH AUG 11 1880		9. AGE (last birthday) 81		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) ATTENDANT CITY HOSPITAL				10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL				11. BIRTHPLACE (City and state or country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY U-S-A			
13a. FATHER'S NAME ROBERT RHODES				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE					
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 NODA HEAD 2801 MANHATTAN LANE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 420° Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 3 Mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ABDOMINAL TUMOR WITH INTERNAL BLEEDING										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 October 16, 1961 to December 3, 1961 and last saw her alive on December 1, 1961 Death occurred at 9:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Leonard N. Piccione M.D.						22b. ADDRESS 6303 Natural Bridge 2 Mo.				22c. DATE SIGNED 12-5-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC. 6 1961		23c. NAME OF CEMETERY OR CREMATORY NEW PICKER CEMETERY ST. LOUIS		23d. LOCATION (City, town, or county) ST. LOUIS		23e. STATE MO.					
24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois				25. DATE RECD. BY LOCAL REG. DEC 6 1961		26. REGISTRAR'S SIGNATURE Loant Smith, M.D.							

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 James O. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Dennis

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.

1-11 AM.
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