

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042415

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10904**

AMENDED

FILED DEC 1 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Mt. Vernon Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 209 W. Dallas Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First DOROTHY	Middle LILLIAN	Last FULTON	4. DATE OF DEATH	Month NOVEMBER	Day 22	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 8/4/1901	9. AGE (last birthday) 60	IF UNDER 1 YEAR	IF UNDER 24 HR
----------------------	-------------------------------	---	----------------------------------	----------------------------------	-----------------	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Miller, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.
--	--	---	---

13a. FATHER'S NAME Frank Neece	13b. MOTHER'S MAIDEN NAME Mae Berry	14. NAME OF HUSBAND OR WIFE Hobart
---------------------------------------	--	---

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 Paul Fulton, Mt. Vernon, Mo.
--	---

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) PERFORATED GASTRIC ULCER		24 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) POST-OPERATIVE CONGENITAL ANEURYSM OF ANTERIOR COMMUNICATING ARTERY, RUPTURED	2 WEEKS
	DUE TO (c) 330x	

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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 **NOV. 13, 1961** to **NOV. 22, 1961** and last saw her/him alive on **NOV. 22, 1961**
Death occurred at **8:08 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. D. Vermillion, M.D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 11/22/61
--	-------------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-24-61	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	23d. LOCATION (City, town, or county) (State) Mt. Vernon, Mo.
--	---------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. NOV 24 1961	26. REGISTRAR'S SIGNATURE Loed Smith, M.D.
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 5 1961

RECEIVED

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 John J. Haines

Licensed Embalmer No. 4108

P. O. Address St. Louis

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.