

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318 Primary Registration District No. 1003 Registrar's No. 10558 STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10558
FILED NOV 28 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 8 days	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		c. CITY OR TOWN Moline Acres	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hosp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 10025 Balboa Dr.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lattie Middle M. Last Rice				4. DATE OF DEATH Month 11 Day 13 Year 61				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/27/98	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler - Ret.		10b. KIND OF BUSINESS OR INDUSTRY Raincoat Mfr.		11. BIRTHPLACE (City and state or country) Dyer, Tenn.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME William Stroud			13b. MOTHER'S MAIDEN NAME Fannie Fletcher		14. NAME OF HUSBAND OR WIFE Joseph W. Rice			
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 Mr. Joseph W. Rice, 10025 Balboa				
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)			left cerebral hemorrhage					2 days
DUE TO (b)			with Rt hemiplegia					
DUE TO (c)			left focal paralysis					2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x						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 <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 11-6-61 to 11-13-61 and last saw her alive on 11-12-61				Death occurred at 6:00 a m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) Domini G. Verdu m.d.			22b. ADDRESS 4500 Olive St			22c. DATE SIGNED 11-13-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 11/15/61	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Louis County Mo.			(State)	
24. FUNERAL DIRECTOR Drehmann-Harral			ADDRESS 1905 Union		25. DATE RECD. BY LOCAL REG. NOV 14 1961		26. REGISTRAR'S SIGNATURE Loal Smith. M.D.	

Dr. Dominic J. Verda
3400 Olive
Po. 7-8400

Hrs. 12:30-6 Mon. & Tues.

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 Warren A. Carve

Licensed Embalmer No. 353X

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.