

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046041

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12165

**FILED JAN 5 1962**

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> , COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in lb <u>5 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis-Little Rock Hospitals, Inc.</u>		d. STREET ADDRESS <u>3559 Halliday</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <u>Mary</u>	Middle <u>Grace</u>	Last <u>Austin</u>	4. DATE OF DEATH	Month <u>Dec.</u>	Day <u>25</u>	Year <u>1961</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27, 1898</u>	9. AGE (last birthday) <u>63 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Neelys Landing Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Otto Schenimann</u>	13b. MOTHER'S MAIDEN NAME <u>Flora Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>James G. Austin (dec)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>James G. Austin</u>	Address <u>St. Louis, Mo.</u>
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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) <u>Pneumonia - Terminal.</u>	
(b) <u>Cardiac Congestive Failure</u>	
(c) <u>Arteriosclerotic Ht. Dis.</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ulycogenase Leukemia - 420.0 H</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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20. 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.)
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20c. TIME OF INJURY	Hour <u>  </u> a.m. <u>  </u> p.m.	Month, Day, Year
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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
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21. I attended the deceased from 1951 to Dec. 25, 1961 and last saw her alive on Dec. 25, 1961  
Death occurred at 5:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Charles Shover, M.D.</u> (Degree or title)	22b. ADDRESS <u>1755 South Grand Blvd.,</u>	22c. DATE SIGNED <u>12-26-61</u>
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23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>	23b. DATE <u>12-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Cape Girardeau Mo.</u>
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24. FUNERAL DIRECTOR <u>Haman Funeral Home</u>	ADDRESS <u>Cape Girardeau, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 27 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>
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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 Frank Prokoff  
Licensed Embalmer No. 4356

P. O. Address Stevens Md

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.