

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-042393
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3731

AMENDED

FILED JAN 9 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>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Length of stay in 1b <u>3 hrs.</u>	c. CITY OR TOWN <u>Creve Coeur</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>851 N. Spodee Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Etta</u> Last <u>Seymour</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1961</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12-11-1874</u>
9. AGE (last birthday) <u>87</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>	11. BIRTHPLACE (City and state or country) <u>Chesterfield, Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>C. H. Murphy</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah E. Hoffman</u>		14. NAME OF HUSBAND OR WIFE <u>William M. (Dcd.)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>William B. Copley-851 N. Spodee Rd</u> Address <u>Creve Coeur</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>UREMIA</u> DUE TO (c) <u>C.N.R. PYELONEPHRITIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 days</u>
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 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 <u>SEPT</u> to <u>Dec</u> and last saw her/him alive on <u>Dec. 27 '61</u> Death occurred at <u>9:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Clarence L Clark</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>new Dallas Rd</u> <u>Ernie Coen 41 mo</u>	22c. DATE SIGNED <u>12/27/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Auto</u>	23b. DATE <u>12-30-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Upper Alton Cemetery</u>	23d. LOCATION (City, town, or county) <u>Alton, Illinois</u>
24. FUNERAL DIRECTOR <u>Baumann Bros. Inc.</u> ADDRESS <u>2504 Woodson Rd., Overland 14</u>	25. DATE RECD. BY LOCAL REG. <u>12-28-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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

David C. Gibson

Licensed Embalmer No.

3464

P. O. Address

Portland

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.