

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-047828

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12251

FILED JAN 19 1962

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| 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 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>604 Baden Ave.,</u> | | d. STREET ADDRESS (If outside, give location) <u>604 Baden Ave.,</u> | |
| Yes <input checked="" 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 Middle Last <u>LEE SCRICAR</u> | | | 4. DATE OF DEATH Month Day Year <u>December 27th, 1961</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/26/93</u> |
| 9. AGE (last birthday) <u>68</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>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u> | 11. BIRTHPLACE (City and state or country) <u>Roumania</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>Unknown</u> | | 13a. FATHER'S NAME <u>not known</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>not known</u> | | 14. NAME OF HUSBAND OR WIFE <u>none</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Dorothy Gartland, 8864 Lowell</u> | | Address | |
| 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>Coronary occlusion;</u> DUE TO (b) <u>Coronary Sclerosis.</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 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 Month, Day, Year a.m. p.m. | 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 _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>J.P.</u> | | 22b. ADDRESS <u>1200 Clark</u> | 22c. DATE SIGNED <u>12/29/61</u> |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>removal</u> | 23b. DATE <u>12/30/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u> | 23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u> |
| 24. FUNERAL DIRECTOR <u>DIEDRICH FUNERAL HOME, 8319 Hallsferry</u> | | 25. DATE RECD. BY LOCAL REG. <u>DEC 28 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INDONESIA

EMBALER

EMBALER

NO. 400

NO. 400

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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 Haines

Licensed Embalmer No. 4108

P. O. Address Haines

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.