

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-003420

STATE FILE NUMBER

318

1003

365

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

**FILED JAN 19 1962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>6 days</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. #1.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7509 Michigan ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Aqurkis</b> Last			4. DATE OF DEATH Month <b>January</b> Day <b>8,</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-1877</b>
9. AGE (last birthday) <b>84</b>		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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Lithuania</b>
12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		13a. FATHER'S NAME <b>Unknown</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>John</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Mrs. Anna Webb</b> Address <b>4350 Seibert ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <b>491x</b>			
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 _____ 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 <b>1/2/62</b> , to <b>1/8/62</b> and last saw her/him alive on <b>1/8/62</b> Death occurred at <b>8:10 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John M. Donoughue MD</b> (Degree or title)		22b. ADDRESS <b>1515 Lafayette Ave.</b>	22c. DATE SIGNED <b>1/8/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 11, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>3901 Mt. Olive Rd. Emay, Mo.</b>
24. FUNERAL DIRECTOR <b>C. Hoffmeister Mortuaries</b> ADDRESS <b>7814 S. Broadway</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 9 1962</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith. M.D.</b>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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

*James C. Hoffmann*

Licensed Embalmer No. 3871

P. O. Address 9814 S. Broad

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;