

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004315

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No. 1003

Registrar's No. 1395

STATE FILE NUMBER

AMENDED

Registration District No.

FILED FEB 7 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>ST. LOUIS, MO</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in lb <u>1 yr.</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. LOUIS CITY HOSP. #1.</u>		d. STREET ADDRESS (If outside, give location) <u>615 Walnut</u>	
Inside Limits 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 <u>CLYDE</u> Middle <u>"</u> Last <u>OWENS</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>31</u> Year <u>1962</u>		
---	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-8-1904</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
--------------------	-------------------------------	--	----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Window washer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (City and state or country) <u>Allenville Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	---	--	--

13a. FATHER'S NAME <u>William Owens</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Walls</u>	14. NAME OF HUSBAND OR WIFE <u>Laverne Bosler</u>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>Mrs. Oma Moore Crystal City Mo.</u>
---	-----------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia Post operative</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Occlusion of iliac Arteries</u>	<u>2 weeks</u>
	DUE TO (c) <u>Generalized Arteriosclerosis</u>	<u>10 years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Emphysema</u>		450'0	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 <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
---	--

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 1/20/62 to 1/31/62 and last saw her/him alive on 1/31/62
Death occurred at 6:35 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Leon L. Tucker MD</u> (Degree or title)	22b. ADDRESS <u>1515 LAFAYETTE AVE</u>	22c. DATE SIGNED <u>1/31/62</u>
---	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-31-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>	23d. LOCATION (City, town, or county) (State) <u>Belleville Ill.</u>
--	--------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>Robins Funeral Home E. St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 1 1962</u>	26. REGISTRAR'S SIGNATURE <u>Leon Smith MD</u>
--	--	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 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

Frank Proff

Licensed Embalmer No. 4356

P. O. Address St Louis, Mo

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.