

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004961

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 13

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST. Louis</u>	b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>COUNTRY Club Hills</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>ST. Louis</u>
Length of stay in lb <u>YRS.</u>		c. CITY OR TOWN <u>COUNTRY Club Hills.</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>7461 CALVIN</u>		d. STREET ADDRESS (If outside, give location) <u>7461 CALVIN</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>Rose</u>	Middle <u>Ella</u>	Last <u>Pannier</u>	Month <u>1-</u>	Day <u>1-</u> Year <u>62</u>
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>12-27-1877</u>	9. AGE (last birthday) <u>84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Caseyville Ky</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>

13a. FATHER'S NAME <u>James H. Hart</u>	13b. MOTHER'S MAIDEN NAME <u>Emily Hawkins</u>	14. NAME OF HUSBAND OR WIFE <u>August</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>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Pearl Doerge</u> Address <u>7461 CALVIN</u>

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>General Arteriosclerosis</u>		<u>?</u>
DUE TO (b)		
DUE TO (c)		

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 <u>8</u> a.m. <u>48</u> Month, Day, Year <u>Oct-1958</u> to <u>Nov. 21, 1961</u> and last saw her <u>Nov. 21, 1961</u> him alive on			
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 Oct-1958 to Nov. 21, 1961 and last saw her Nov. 21, 1961 him alive on Nov. 21, 1961
 Death occurred at 8 48 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Albert Wall M.D.</u>		22b. ADDRESS <u>5322 Helen Ave</u>	22c. DATE SIGNED <u>1/3/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-4-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. Matthews</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>

24. FUNERAL DIRECTOR <u>O'Sullivan Mucke Kron</u> ADDRESS <u>8806 Jennings Road</u>	25. DATE RECD. BY LOCAL REG. <u>1-3-62</u>	26. REGISTRAR'S SIGNATURE <u>John Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dw Al Wall.
5322 Helms
9-10-Wed

STATE OF MA 03117

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 Hester J. Lane Jr

Licensed Embalmer No. 4800

P. O. Address Kirkwood 27 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.