

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007952

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No. 1003

Registrar's No. 1640

STATE FILE NUMBER

AMENDED

Registration District No. FILED FEB 16 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.	Length of stay in 1b 10 Yrs.	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1721 S. 9th	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last EVA DAVIS			4. DATE OF DEATH Month Day Year FEB. 6, 1962			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/10/04	9. AGE (last birthday) 58	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Juda, Wisconsin	12. CITIZEN OF WHAT COUNTRY USA
--	---	---	------------------------------------

13a. FATHER'S NAME William Worley	13b. MOTHER'S MAIDEN NAME Grace Berryman	14. NAME OF HUSBAND OR WIFE Lester
--------------------------------------	---	---------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. Charles Phillips, Monroe, Miss.	Address Wisconsin
---	------------------------------------	---	----------------------

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>Subarachnoid Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	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) <u>Diabetes Mellitus and Chronic Pyelonephritis</u>		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 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 <u>1/18/62</u> to <u>2/6/62</u> and last saw her/him alive on <u>2/6/62</u> Death occurred at <u>7:25</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Card L. Beards, M.D.</u> (Degree or title)	22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	22c. DATE SIGNED <u>2/6/62</u>
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2/9/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Co., Mo.</u>
---	----------------------------	---	---

24. FUNERAL DIRECTOR <u>McLaughlin, 2301 Lafayette, St. Louis Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 8 1962</u>	26. REGISTRAR'S SIGNATURE <u>Head Smith, M.D.</u>
---	---	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 3 2
 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 James R. Chapman
Licensed Embalmer No. 4550
P. O. Address St. Louis,

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.