

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-012587

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3090**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 6 1962

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN		Inside Limits	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		IF UNDER 1 YEAR	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE		Months		Days	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		Year	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO (b)		DUE TO (c)		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 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		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		11:10 P		m		on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
24. FUNERAL DIRECTOR		ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE			

1. PLACE OF DEATH: a. COUNTY: **St. Louis**; b. CITY: **St. Louis**; Length of stay: **2 Days**; c. CITY OR TOWN: **Pine Lawn**; Inside Limits: Yes No
 2. USUAL RESIDENCE: a. STATE: **Mo.**; b. COUNTY: **St. Louis**; c. CITY OR TOWN: **Pine Lawn**; Inside Limits: Yes No
 3. NAME OF DECEASED: **Madie F. Dewhirst**; 4. DATE OF DEATH: **3 19 1962**
 5. SEX: **Female**; 6. COLOR OR RACE: **White**; 7. Married: Never Married: Widowed: Divorced: ; 8. DATE OF BIRTH: **7-7-87**; 9. AGE: **74**
 10a. USUAL OCCUPATION: **Practical Nurse**; 10b. KIND OF BUSINESS OR INDUSTRY: **Nursing**; 11. BIRTHPLACE: **Columbia, Mo.**; 12. CITIZEN OF WHAT COUNTRY: **U.S.A.**
 13a. FATHER'S NAME: **Dave W. Morris**; 13b. MOTHER'S MAIDEN NAME: **Delcie Cord**; 14. NAME OF HUSBAND OR WIFE: **S. L. Dewhirst**
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? **No**; 16. SOCIAL SECURITY NO.: **4200**; 17. INFORMANT: **William J. Hilliard**, Address: **6100 Joliet**
 18. CAUSE OF DEATH: PART I. IMMEDIATE CAUSE (a): **ACUTE MYOCARDIAL INFARCTION**; DUE TO (b): **ARTERIOSCLEROTIC HT. DISEASE**; DUE TO (c): **4200**; INTERVAL BETWEEN ONSET AND DEATH: **3 da**
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: **4200**; PART III. If deceased was female was there a pregnancy in last 90 days: No
 19. WAS AUTOPSY PERFORMED? **NO**; 20a. ACCIDENT: SUICIDE: HOMICIDE: ; 20b. DESCRIBE HOW INJURY OCCURRED: **4200**
 20c. TIME OF INJURY: **11:10 P**; 20d. INJURY OCCURRED WHILE AT WORK: NOT WHILE AT WORK: ; 20e. PLACE OF INJURY: **4200**; 20f. CITY, TOWN, OR LOCATION: **St. Louis**; COUNTY: **St. Louis**; STATE: **Mo.**
 21. I attended the deceased from **JAN 1955** to **PRESENT** and last saw her/him alive on **3/19/62**; Death occurred at **11:10 P** m on the date stated above, and to the best of my knowledge, from the causes stated.
 22a. SIGNATURE: **John J. Riley MD**; 22b. ADDRESS: **6807 W. Florissant**; 22c. DATE SIGNED: **3/24/62**
 23a. BURIAL, CREMATION, REMOVAL: **Removal**; 23b. DATE: **3-23-62**; 23c. NAME OF CEMETERY OR CREMATORY: **Oak Grove Cemetery**; 23d. LOCATION: **St. Louis County Mo.**
 24. FUNERAL DIRECTOR: **Drehmann-Harral**; ADDRESS: **1905 Union Blvd.**; 25. DATE RECD. BY LOCAL REG.: **MAR 22 1962**; 26. REGISTRAR'S SIGNATURE: **Edna Smith, M.D.**

Dr. John J. Riley
6807 W. Florissant
By 5-5335
Hrs. 10-12 Thurs.

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 Albert R. Thompson

Licensed Embalmer No. 4257

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.