

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-012650

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3618**

FILED APR 12 1962

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|---|------------------|---|---------------------------|--|---|------------------------------|---------------------------------------|---------------------------|------------------|--|------|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | c. CITY OR TOWN | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| ST. LOUIS, MISSOURI | | BARNES HOSPITAL | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Missouri | | Crawford | Cuba | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | First | Middle | Last | 4. DATE OF DEATH | | Month | Day | Year | |
| OLIVET | | | N. | | FOX | APRIL | | 3 | | 1962 | |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HR | |
| Female | White | | | 9/30/1888 | | 73 | | Months | Days | Hours | Min. |
| 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 | | | | | |
| Retired Owner | | Resort | | East St. Louis, Ill. | | U.S. | | | | | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | | 14. NAME OF HUSBAND OR WIFE | | | | | |
| Philip Wolf | | | Emma Plappert | | | Chester | | | | | |
| 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 | | | | | | |
| No | | | None | | Donald Fox, Cuba, Mo. | | | | | | |
| 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) | | | | | | | | | | 1 WEEK | |
| DUE TO (b) | | | | | | | | | | 20 YEARS | |
| DUE TO (c) | | | | | | | | | | 4200 | |
| 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 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 <u>MARCH 18, 1944</u> to <u>APRIL 3, 1962</u> and last saw her/him alive on <u>APRIL 3, 1962</u> Death occurred at <u>11:58 A.M.</u> 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 | | |
| <i>C. D. Hamilton, M.D.</i> | | | M. D. | | | BARNES HOSPITAL | | | 4/3/62 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town, or county) | | (State) | | |
| Removal | | 4-5-62 | | Kinder Cemetery | | | Cuba, Mo. | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | |
| Hoener Funeral Home, Cuba, Mo. | | | | | | APR 5 1962 | | <i>Loan Smith, M.D.</i> | | | |

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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 Stanley H. Dixon

Licensed Embalmer No. 4193

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.