

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

3259 -62-013141
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. _____ Registrar's No. _____

FILED APR 6 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

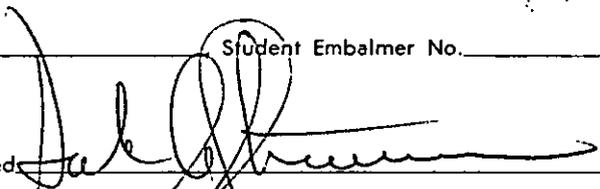
BY AFFIDAVIT OF

| | | | | | | | | |
|--|--|---|------------------------------------|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | |
| | | St. Louis | | | Mo. | | | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION | | 4012 Juniata St. | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) | | 4012 Juniata St. | |
| | | | | | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | First | Middle | Last | 4. DATE OF DEATH Month Day Year | | |
| FLORENCE | | | J. | | ST. JEAN | Mar. 25 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 | | 3-25-1879 | | 83 | Months | Days | Hours |
| 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 | | |
| Housework | | At Home | | St. Louis, Mo. | | U.S.A. | | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | | 14. NAME OF HUSBAND OR WIFE | | |
| Maximilian Caffer | | | Anna Hahn | | | Late Stephen Louis St. Jean | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | None | | Audrey St. Jean | | 4012 Juniata St. | | |
| 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) | | | | | | | | 3 days. |
| DUE TO (b) | | | | | | | | 3 days. |
| DUE TO (c) | | | | | | | | unknown. |
| 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. |
| Carcinoma of cecum. 420.04 | | | | | | | | <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. Month, Day, Year 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>Aug. 18, 1961</u> to <u>3-25-62</u> and last saw her ^{her} alive on <u>3-25-62</u> Death occurred at <u>4:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>Raymond J. Martin, MD</i> | | | | (Degree or title) | | 22b. ADDRESS <i>5203 Chippewa St.</i> | | 22c. DATE SIGNED <i>3-26-62</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | (State) | |
| Removal | | Mar. 28, 1962 | Sunset Burial Park | | St. Louis Co. Mo. | | | |
| 24. FUNERAL DIRECTOR <i>Kriegshausner</i> | | | | ADDRESS <i>4228 S. Kingshighway Blvd.</i> | | 25. DATE RECD. BY LOCAL REG. <i>MAR 27 1962</i> | | 26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i> |

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 _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____
Student Embalmer No. _____
Licensed Embalmer No. 4533
P. O. Address _____

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.