

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013481

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1041

FILED APR 6 1962

VS 300
Rev. 4/59

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94200
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hanley Hills		Length of stay in lb 65 years	c. CITY OR TOWN Hanley Hills		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7809 Monroe Dr.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7809 Monroe Dr.	
3. NAME OF DECEASED (Type or print) Eva Jane GLAZE			4. DATE OF DEATH Month March Day 30 Year 1962		
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-4-1879	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days 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 Own home	11. BIRTHPLACE (City and state or country) Bourbon, Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Barter Caldwell		13b. MOTHER'S MAIDEN NAME Elizabeth Pryor		14. NAME OF HUSBAND OR WIFE John G. Glaze	
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. None		17. INFORMANT Address Mrs. William J. Kraatz, 1304 San Jacinto(10)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH
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). Rheumatoid arthritis.				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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>May 3, 1954</u> to <u>Mar. 30, 1962</u> and last saw her <u>alive</u> on <u>Mar. 26, 1962</u> Death occurred at <u>10:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Hugo F. Bergman M.D.			22b. ADDRESS 3720 Washington		22c. DATE SIGNED 3/31/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-2-62	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County MO.
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, 6175 Delmar Blvd.			25. DATE RECD. BY LOCAL REG. 3-31-62		26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>

USE BLACK INK OR TYPEWRITER RIBBON

(In office from 9:00 A.M. to 11:00 A.M. Saturday)

Dr. H.F. Bergman
3720 Washington

Phone: JE 3-6204

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 *Joseph McCallister*

Licensed Embalmer No. *2468*

P. O. Address *6195 Dillmar*

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.