

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-013685

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 934

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 30 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch</b>		Length of stay in 1b <b>27 days</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2613a Palm</b>
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Smith</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/15/1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Tester</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Busman Fuge Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>
13a. FATHER'S NAME <b>Thomas Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Breen</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>Robert Koch Hospital Record</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
DUE TO (b) <b>Cerebral arteriosclerosis</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) <b>Arteriosclerotic heart disease, Chronic nephritis, with uremia</b>			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 <b>2-20-62</b> to <b>3-19-62</b> and last saw <del>her</del> <b>her</b> alive on <b>3-19-62</b> Death occurred at <b>11:45</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Harold E. Russell</i> M.D.		22b. ADDRESS <b>Robert Koch Hospital</b>	22c. DATE SIGNED <b>3-20-62</b>
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>3/22/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Collier Mortuary, St. Ann, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-20-62</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann Mo.

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.