

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020983

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5500 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JUN 7 1962**

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED  
6/21/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
5 Months

SHOULD READ  
19 Weeks

ITEM NO.  
18c

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF Attendant

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>MADISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b <u>2 WKS</u>	c. CITY OR TOWN <u>ALTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>815 E. 5 St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>MARION</u> Last <u>SHAIN</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1962</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-1930</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	9. AGE (last birthday) <u>31</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. FATHER'S NAME <u>ORLIN NELSON</u>		11b. MOTHER'S MAIDEN NAME <u>Lillian Guetlman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Robert Shain</u>		Address <u>Alton Ill</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>			INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ACUTE BLOOD LOSS</u> <u>645.0</u>			<u>2 HOURS</u>
DUE TO (c) <u>ABDOMINAL PREGNANCY (RUPTURED)</u>			<u>19 Weeks</u> <del>5 MONTHS</del>
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 checked="" type="checkbox"/> Yes <input 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>MAY 17, 1962</u> to <u>MAY 31, 1962</u> and last saw her/him alive on <u>MAY 31, 1962</u> Death occurred at <u>5:40 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. D. Vermillion, M.D.</u> (Degree or title)		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>6/1/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>6-1-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Jerseyville ILL.</u>
24. FUNERAL DIRECTOR <u>JACOBY BROS</u> ADDRESS <u>Jerseyville</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 1 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loant Smith, M.D.</u>

STATE OF ALABAMA

**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 Frank Proff

Licensed Embalmer No. 4356

P. O. Address St Louis 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.

ALABAMA BOARD OF EMBALMERS