

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-021293

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1355 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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| FILED MAY 23 1962 | |
| 1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch Mo</u> Length of stay in lb <u>603 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROBT KOCH HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> c. CITY OR TOWN <u>ST LOUIS</u> d. STREET ADDRESS (If outside, give location) <u>6215 MARMADUKE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>NMI</u> Last <u>DOUGLAS</u> | |
| 4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1962</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>White</u> |
| 7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 9/21</u> |
| 9. AGE (last birthday) <u>90</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Housewife</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (City and state or country) <u>ST Louis Mo</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>John COOK</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Martha Unknown</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Robert Douglas</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>None</u> | |
| 17. INFORMANT Address <u>Hospital Record Robt Koch Hosp</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>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>years?</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | |
| 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>Sept 6, 1960</u> to <u>Feb 2, 1962</u> and last saw her <u>alive</u> on <u>5/1/62</u> Death occurred at <u>3:05</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) <u>Frank Cohen MD</u> | |
| 22b. ADDRESS <u>Robt Koch Hosp Koch Mo</u> | |
| 22c. DATE SIGNED <u>5/2/62</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>5-4-62</u> |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u> | |
| 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>JAY B. SMITH, Maplewood, Mo.</u> ADDRESS _____ | |
| 25. DATE RECD. BY LOCAL REG. <u>5-3-62</u> | |
| 26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u> | |

USE BLACK INK OR TYPEWRITER RIBBON

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 *A. E. Burgess*

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.