

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029060

6794

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST. LOUIS</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>ST. LOUIS</u>  |   | c. CITY OR TOWN <u>Ferguson</u>   |  |
| Length of stay in 1b   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>De Paul Hosp</u>   |   | d. STREET ADDRESS (If outside, give location)<br><u>1031 Thatcher</u>   |  |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Virgil</u> Middle <u>R.</u> Last <u>Proost</u>   |   |   | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>8</u> Year <u>1962</u>   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>5-17-1914</u>   |
| 9. AGE (last birthday)<br><u>50</u>  |   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HR<br>Hours _____ Min. _____   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Cost Accountant</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Krey Packing Co</u>   | 11. BIRTHPLACE (City and state or country)<br><u>ST. LOUIS, MO</u>   |
| 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |   | 13a. FATHER'S NAME<br><u>Theo Proost</u>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><u>Mary Boeding</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Anna Marie</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |   | 17. INFORMANT<br><u>ANNA MARIE PROOST THATCHER</u><br>Address <u>1031</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HT. DISEASE</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>AR<sup>TH</sup>EROSCLEROSIS GENERALIZED</u><br>DUE TO (c) <u>420.0</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 yrs</u><br><u>3 yrs</u>   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>JAN. 1962</u> to <u>PRESENT</u> and last saw her alive on <u>7/8/62</u><br>Death occurred at <u>9:00</u> P on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>John Hiley MD</u>   |   | 22b. ADDRESS<br><u>6807 W. FLORISSANT</u>   | 22c. DATE SIGNED<br><u>7/10/62</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE<br><u>7-11-62</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Calvary</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>ST. LOUIS MO</u>   |
| 24. FUNERAL DIRECTOR<br><u>O'Sullivan Muehle Keon</u>  | ADDRESS<br><u>Jennings Rd</u>   | 25. DATE RECD. BY LOCAL REG.<br><u>JUL 10 1962</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Loal Smith, M.D.</u>   |

John Riley  
6807 W. 7th Lane  
10-12-7603

**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 Herbert J. Lee Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 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.