

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029132

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7047

FILED JUL 31 1962

VS 300 Rev. 4/59	DATE AMENDED		AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1					
2		21 59			
3					
4		1			
5		2			
6					
7		0			
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10					
11					
12		58-0			
13					
58					
ITEM NO.	SHOULD READ				

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY					
		St. Louis, Mo.				Mo							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)							
Deaconess Hospital						5008 Alabama							
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH							
First Middle Last						Month Day Year							
FLORENCE J. SCHAEFER						7/16/62							
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR	
F		W				11-13-1883		78		Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY					
Retired Minister						St. Louis, Mo.		USA					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE					
Jacob R. Shelton				Isabell Kincaid				George F. -----					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address							
No						Myrtle Shores, 8118 Parkridge Dr							
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)													
Uremia													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
DUE TO (b)													
Bilateral uterine obstruction													
DUE TO (c)													
Carcinoma of cervix.													
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.					
								171X <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>March 1962</u> to <u>July 1962</u> and last saw her/him alive on <u>16 July 1962</u> . Death occurred at <u>3:24 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title)				22b. ADDRESS				22c. DATE SIGNED					
Ralph E. Woods M.D.				950 Francis Place				18 July 1962					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)							
Cremation		7/19/62		Valhalla		St. Louis County, Mo.							
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE							
John L. Ziegenhein & Sons, 7027 Gravois				JUL 18 1962		Karl Smith M.D.							

**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 E. J. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Graves

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.