MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032408

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8031

FILED AUG 22 1962

DO NOT WRITE ON THIS STUB — AMENDED

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY ST. LOUIS

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Length of stay in 1b 1 WEEK

c. CITY OR TOWN NORMANDY — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) DE PAUL HOSPITAL — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 5351 GLADSTONE — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First HELEN Middle N. Last DYE

4. DATE OF DEATH Month AUG. Day 15, Year 1962

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 3-5-1909

9. AGE (last birthday) 53 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY AT HOME

11. BIRTHPLACE (City and state or country) TEXARKANA TEX.

12. CITIZEN OF WHAT COUNTRY U S A

13a. FATHER'S NAME BEN LUNSFORD

13b. MOTHER'S MAIDEN NAME NELLIE KERSHAW

14. NAME OF HUSBAND OR WIFE HORACE A. DYE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Don't know

17. INFORMANT HORACE A. DYE Address 5351 GLADSTONE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH 6 mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 581.0
DUE TO (c)
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 July 31, 1962, to Aug 15, 62 and last saw her alive on 8-15-62
Death occurred at 10 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M D Johnson M D

22b. ADDRESS Ferguson MO

22c. DATE SIGNED 8-17-62

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE AUG. 18, 62

23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM.

23d. LOCATION (City, town, or county) ST. LOUIS COUNTY (State) MO

24. FUNERAL DIRECTOR STROOT CARROLL ADDRESS 4600 NATURAL BRIDGE

25. DATE RECD. BY LOCAL REG. AUG 17 1962

26. REGISTRAR'S SIGNATURE Earl 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_____ Signed M W Rueter

Signature of Student Embalmer

Licensed Embalmer No. 4865

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.