

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033282

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2444

FILED SEP 11 1962

DO NOT WRITE ON THIS STUB	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
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1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>18 days</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>Robert Koch Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>3630 Botanical</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Mae</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1962</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>1/11/91</u>
9. AGE (last birthday) <u>71</u>		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) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles Kimball</u>	
13b. MOTHER'S MAIDEN NAME <u>Viola Wall</u>		14. NAME OF HUSBAND OR WIFE <u>James Smith</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 <u>JAMES D SMITH</u>		Address <u>3630 BOTANICAL</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>Organized pulmonary Emboli</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of uterus</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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.) <u>Fall- out of bed</u>	
20c. TIME OF INJURY Hour <u>7/10/62</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis,</u>	COUNTY	STATE
21. I attended the deceased from <u>8/3/62</u> to <u>8/21/62</u> and last saw her/him alive on <u>8/21/62</u>		Death occurred at <u>5 /10 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Bernard Friedman M.D</u> (Degree or title)		22b. ADDRESS <u>Koch Hosp, Koch Mo.</u>	22c. DATE SIGNED <u>8-21-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>AUG 25 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST. MARCUS CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>
24. FUNERAL DIRECTOR <u>Thomas Kutz</u> ADDRESS <u>2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>8-22-62</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy M.D.</u>

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Glavin

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.