

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036081

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

938E

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. Primary Registration District No. Registrar's No.

FILED OCT 11 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
St. Louis		St. Louis		10 weeks	Missouri		St. Louis		Maplewood		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
Park Lane Hospital				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	7317 Elm Avenue				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
GERALDINE MARY DONNEWALD						Sept. 29, 1962						
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		Months	Days	Hours	Min.
female	white		Feb. 14, 1889	73								
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				
housewife			at home		St. Louis, Missouri			U. S. A.				
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE				
Richard J. Barrett				Ann B. Smythe				--				
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						Mrs. Harriet Jacobs			7317 Elm Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Informant of Old Age</i>											5 yrs.	
Conditions, if any, which gave rise to above cause last stated, the underlying cause last. <i>10-16</i> DUE TO (b) <i>904.9-45</i> 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.				
<i>fracture, left hip 3 mos</i>								<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 <i>May 1962</i> to <i>29 Sept 62</i> and last saw her alive on <i>29 Sept 1962</i>												
Death occurred at <i>10:30 AM</i> <i>3M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <i>John A. Croghan M.D.</i> (Degree or title)						22b. ADDRESS <i>Maplewood Mo</i>			22c. DATE SIGNED <i>10/1/62</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)					
burial		Oct. 2, 1962		Calvary Cemetery			St. Louis, Missouri					
24. FUNERAL DIRECTOR ADDRESS					25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
M.J. Croghan, 7146 Manchester Avenue					OCT 1 1962		<i>Lois Smith, M.D.</i>					

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

W E Morris

Licensed Embalmer No. 3360

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.