

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036115

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9133** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 28 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 400X3				
3				
4 1				
5 2				
6				
7 1				
8 2				
9	MEDICAL CERTIFICATION	SHOULD READ	BY AFFIDAVIT OF	
10				
11				
12 81-0				
13				
81				

1. PLACE OF DEATH a. COUNTY St. Louis		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		c. CITY OR TOWN Overland	
Length of stay in 1b 49 Years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If outside, give location) 47 E. Sherwood Drive	
Inside Limits 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 Middle Last Marie Evis Erb			4. DATE OF DEATH Month Day Year September 21, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1883
9. AGE (last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Cheyenne, Wyoming
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Frederick Wilhelm Evis	
13b. MOTHER'S MAIDEN NAME Catherine Goetch		14. NAME OF HUSBAND OR WIFE Henry William Erb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mr Walter Erb 47 E. Sherwood Drive
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with skeletal metastases			INTERVAL BETWEEN ONSET AND DEATH 2-122 yrs.
DUE TO (b) _____ DUE TO (c) _____			170X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis			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 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 1962		COUNTY STATE
21. I attended the deceased from Apr. 12, 1960 , to September 21 and last saw her alive on September 20, 1962 Death occurred 2:30 a. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <i>W. Baumgartner, M.D.</i>		22b. ADDRESS 3720 Washington Blvd. St. Louis	22c. DATE SIGNED 9/21/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Auto)	23b. DATE 9/23/62	23c. NAME OF CEMETERY OR CREMATORY E. Lawn Memorial Park Cem	23d. LOCATION (City, town, or county) (State) Mexico, Missouri
24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd		25. DATE RECD. BY LOCAL REG. SEP 21 1962	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>

Dr. Baumgarten

Beaumont Bldg

Je. 3-6720

2 to 5 P.M.

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 James M. Cullah

Licensed Embalmer No. 2460

P. O. Address 6175 Delmar

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.