

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036128

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8948

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 24 1962

| | | | | | | | | | | |
|---|------------------|---|-----------------------------------|--|---|------------------------------|---|--|----------------|---|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in lb | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | c. CITY OR TOWN | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 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) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | | First | Middle | Last | 4. DATE OF DEATH | | Month | Day | Year |
| Annie | | | Featherson | | | 9-13-62 | | | | |
| 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 | |
| Female | Col. | | | 7-18-82 | 80 | | 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 | | | |
| Housewife | | | None | | Ala. | | U.S.A. | | | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | | 14. NAME OF HUSBAND OR WIFE | | | | |
| Isaac Dukas | | | Minerva | | | Deceased | | | | |
| 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 | | | None | | Hennie Crawford | | 2251 Dickson St. Apt 801 | | | |
| 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>Acute Pulmonary Embolism</u> | | | | | | | | | | |
| DUE TO (b) <u>Mural Thrombus in Right Auricle</u> | | | | | | | | | | |
| DUE TO (c) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | | | |
| 420.0 | | | | | | | | | | |
| 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 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 | | 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 | | 11-2-61 | | to | | 9-13-62 | | and last saw her/him alive on | | 9-13-62 |
| Death occurred at <u>5:10 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | |
| 22a. SIGNATURE | | | | | 22b. ADDRESS | | | 22c. DATE SIGNED | | |
| <u>George M. Janaka, MD</u> | | | | | <u>5600 Arsenal</u> | | | <u>9/14/62</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town, or county) (State) | | | |
| Removal | | 9-19-1962 | | Washington Park Cemetery | | | St. Louis (County) Mo. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | |
| Ellis Funeral Home-2820 Stoddard St. | | | | | | SEP 17 1962 | | <u>Roal Smith, M.D.</u> | | |

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 Yulston E. Cook

Licensed Embalmer No. 4198

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.