

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040078  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10140**

**FILED OCT 29 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 type="checkbox"/> No <input type="checkbox"/>																																									
a. COUNTY		St. Louis				Mo.				St. Louis		Yes <input type="checkbox"/> No <input type="checkbox"/>																																									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN						c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION						Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>																																									
St. Louis						St. Anthony Hospital						Yes <input type="checkbox"/> No <input type="checkbox"/>																																									
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH						Month		Day		Year																																					
First						Middle						Last																																									
JOHN						F.						CARROLL																																									
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																	
Male						White												5-3-1885						77						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																	
Plasterer (Retired)																								New York, N.Y.												U.S.A.																	
13a. FATHER'S NAME												13b. MOTHER'S MAIDEN NAME												14. NAME OF HUSBAND OR WIFE																													
James Carroll												Margaret Tracy												Late Mary E. Carroll																													
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												Margaret Alsmeyer 4362 Itaska St.																													
18. CAUSE OF DEATH (Enter only one cause per line)												PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH																													
												IMMEDIATE CAUSE (a)												2- wks																													
												DUE TO (b)																																									
												DUE TO (c)																																									
												Cerebrovascular accident																																									
												Generalized and																																									
												cerebral arteriosclerosis												years																													
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.																																									
												331x												<input type="checkbox"/> Yes <input 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				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																																					
				June 16, 1960				Oct 22, 1962																																													
21. I attended the deceased from												and last saw him alive on																																									
9:30 A.												10/22/62																																									
Death occurred at												m on the date stated above, and to the best of my knowledge, from the causes stated.																																									
22a. SIGNATURE												(Degree or title)												22b. ADDRESS												22c. DATE SIGNED																	
Carroll Leudin MD																								4268 Delor												10/23/62																	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)																																									
Burial				Oct. 24, 1962				New St. Marcus Cemetery				St. Louis, Mo.																																									
24. FUNERAL DIRECTOR												ADDRESS												25. DATE RECD. BY LOCAL REG.												26. REGISTRAR'S SIGNATURE																	
Kriegshauser 4228 S. Kingshighway Blvd.																								OCT 23 1962												Loan Smith, M.D.																	

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**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 R. Dunn

Licensed Embalmer No. 4527

P. O. Address \_\_\_\_\_

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.