

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9940-62-040122
STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 29 1962

VS 300
Rev. 4/59

1
2 **2/8**
3
4 **1**
5 **2**
6
7 **0**
8 **1**
9
10
11
12 **80-0**
13 **80**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Louis		Length of stay in 1b Over 10 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Former 4393 Chouteau		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Litterest Last Corsealis			4. DATE OF DEATH Month October Day 16th Year 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 9-8-1881		9. AGE (last birthday) 82 yrs		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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country) St. Genevieve Co., Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME ? Litterst			13b. MOTHER'S MAIDEN NAME ?			14. NAME OF HUSBAND OR WIFE Florman, Corsealis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism from left femoral vein DUE TO (b) Arteriosclerotic-cardio-vascular-renal disease. DUE TO (c) 442x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									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 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 _____ 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 May 19, 1952 to October 16, '62 and last saw her/him alive on October 16, 1962 Death occurred at 2:25 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE A. J. Heusler M.D.				(Degree or title)		22b. ADDRESS 5400 Arsenal St.		22c. DATE SIGNED 10-17-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-19-62	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)		
24. FUNERAL DIRECTOR Alexander & Sons, 6175 Delmar Blvd.				ADDRESS		25. DATE RECD. BY LOCAL REG. OCT 17 1962		26. REGISTRAR'S SIGNATURE Roan Smith, M.D.	

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 Joe E McCallister

Licensed Embalmer No. 2460

P. O. Address 6176 Allman

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.