

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

984062-040133
STATE FILE NUMBER
62-040133

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED OCT 19 1962

VS 300
Rev. 4/59

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2 *2/5*
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4 *1*
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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 St. Louis		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Geitner Home 5000 So. Bdwy.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5000 So. Broadway				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA L CURTIS						4. DATE OF DEATH Month Day Year October 14 1962					
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/25/1878		9. AGE (last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At. Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Otterville Ill.		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Wm. Curtis				13b. MOTHER'S MAIDEN NAME Sarah Dodson				14. NAME OF HUSBAND OR WIFE Never Married			
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. No		17. INFORMANT Address Victor Dodson #20 Oak Haven					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease										INTERVAL BETWEEN ONSET AND DEATH 2 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis											
DUE TO (c) 4200											
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 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 1958 to 10/11/62 and last saw her/him alive on 10/11/62 Death occurred at 4:45 PM on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Norman P. Kowalen MD						22b. ADDRESS 3720 Washington St 50 Louis 8 Mo			22c. DATE SIGNED 10/15/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/16/1962		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.		23d. LOCATION (City, town, or county) Jerseyville Ill.		(State)			
24. FUNERAL DIRECTOR ADDRESS Lupton Chapel 7233 Delmar Blvd.						25. DATE RECD. BY LOCAL REG. OCT 15 1962		26. REGISTRAR'S SIGNATURE Loan Smith. M.D.			

Curtis
Dr. Knowlton
City Vise

3700 W. Washington

O.P.V. - 4935

WY 3-1352

Barnes Hospital 930 Ind.

Dept.

#145

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

Arnold W. Schoene

Licensed Embalmer No. 3864

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.