

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

10121 -62-040206
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 XC-1 200 714

VS 300
Rev. 4/59

1

3

4 0

5 1

6

7 1

8 1

9 +

10

11

1293-0

13

83

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, MISSOURI		Length of stay in 1b 72 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY Union		c. CITY OR TOWN MILL CREEK		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND AVE.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) NONE				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOEL M. FOUTCH						4. DATE OF DEATH 10/19/62		First		Last	
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/3/92		9. AGE (last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER, RETIRED				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) JEFFERSON COUNTY, ILLINOIS, U.S.A.		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME JOEL FOUTCH				13b. MOTHER'S MAIDEN NAME MAHALEA CHRISTIAN				14. NAME OF HUSBAND OR WIFE MAGEL FOUTCH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I				16. SOCIAL SECURITY NO.		17. INFORMANT Address MAGEL FOUTCH (WIDOW) SEE #2					
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA WITH EARLY BRONCHOPNEUMONIA DUE TO (b) METASTATIC CARCINOMA OF THE NECK DUE TO (c) _____ 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 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 a.m. p.m.		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.) VA		20f. CITY, TOWN, OR LOCATION VAH, ST. LOUIS, MO.		COUNTY		STATE	
21. // attended the deceased from 8/8/62 to 10/19/62 and last saw him XXX alive on 10/19/62 Death occurred at 1:50 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.						22a. SIGNATURE <i>[Signature]</i> W. H. LACKNER		22b. ADDRESS M.D. VAH, ST. LOUIS, MO.		22c. DATE SIGNED 10/19/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-22-62		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) Mounds City, Illinois.		(State)			
24. FUNERAL DIRECTOR Farnsworth Funeral Home, Tamms, Illinois.				ADDRESS		25. DATE RECD. BY LOCAL REG. OCT 22 1962		26. REGISTRAR'S SIGNATURE <i>[Signature]</i> Loard 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 Harry E. Monroe

Licensed Embalmer No. 4495

P. O. Address St. Louis

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.