

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044013

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11705

STATE FILE NUMBER

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"/>	
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								
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 Months Days		IF UNDER 24 HR 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				
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE					
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				
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>Cerebral anoxia (suspected)</u> DUE TO (b) <u>ASHD with atrial fibrillation</u> DUE TO (c) <u>Pheochromocytoma @ Adrenal suspected</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute diverticulitis Sigmoid</u> 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.) <u>4200</u>							
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.) <u>1:50 PM</u>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>12-3-62</u> to <u>12-4-62</u> and last saw her alive on <u>12-4-62</u> Death occurred at <u>12:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>R.M. Turner, M.D.</u>						22b. ADDRESS		22c. DATE SIGNED <u>12-5-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		23e. (State)			
<u>BURIAL</u>		<u>DEC. 7 1962</u>		<u>NEW PICKER CEM</u>		<u>ST. LOUIS</u>		<u>MO.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutie 2906 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>DEC 6 - 1962</u>		26. REGISTRAR'S SIGNATURE <u>Roal Smith M.D.</u>					

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300 Rev. 4/59	
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74

**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

*Eleana Province*

Licensed Embalmer No.

*3403*

P. O. Address

*2906 Grassi*

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.