

2758

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

11324-62-044983

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

FILED DEC 7 1962

V5 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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"/>			
St. Louis		St. Louis				Mo.				St. Louis		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"/>					
Hömer Phillips Hospital						443 1 St. Ferdinand									
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			
John			Tunstell						11			22 62			
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR.			
Male		Col.				4-14-02		60		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			
Minister								Troy, Missouri				USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
Peter T unstell				Ellen				Addie							
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								Addie Tunstall				4431 St. Ferdinand			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Cancer (Terminal) of stomach</i>															
DUE TO (b) <i>Asterix sclerosis</i>															
DUE TO (c) <i>151X</i>															
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 type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT		SUICIDE		HOMICIDE		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 _____ to _____ and last saw her/him alive on _____.															
Death occurred at <i>5:55</i> P. m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <i>Joseph Dickson</i>						(Degree or title) <i>Physician</i>						22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>11-26-62</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)					
Removal				11-27-62		Father Dickson Cem.				Kirkwood, Mo.					
24. FUNERAL DIRECTOR						ADDRESS						25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
A.L. Beal Und. Co.						4303 Delmar						NOV 26 1962		<i>Boad Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

FILED IN 1998

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 Arthur L. Heallier

Licensed Embalmer No. 4221

P. O. Address: 3100 Boston

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.