

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048154

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12643** STATE FILE NUMBER

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. <del>FILED</del> <b>JAN 10 1963</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE <b>Illinois</b>	b. COUNTY <b>St. Clair</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>East St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Infirmary</b>		d. STREET ADDRESS (If outside, give location) <b>1123 Tudor Avenue</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>AMANDA BATUPS</b>		4. DATE OF DEATH Month Day Year <b>December 29, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>Separated</b>	8. DATE OF BIRTH <b>3/5/1892</b>
9. AGE (last birthday) <b>70</b>		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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Yazoo City, Miss.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>JOHN NEWMAN</b>	
13b. MOTHER'S MAIDEN NAME <b>PRIGILLA CLARK</b>		14. NAME OF HUSBAND OR WIFE <b>ALF BATUPS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Marie Woods, 1123 Tudor Avenue, East St. Louis, Illinois</b>
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) <b>Cerebral Hemorrhage</b>			<b>12 5 days</b>
DUE TO (b) <b>Hypertensive Vascular Disease</b>			<b>Unknown</b>
DUE TO (c) <b>331x</b>			
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 <b>12-17-62</b> to <b>12-29-62</b> and last saw her alive on <b>12-29-62</b> Death occurred at <b>10:30 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <b>M. E. Smith, M.D.</b>		22b. ADDRESS <b>2715 Union St. Union, Mo</b>	22c. DATE SIGNED <b>12-31-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/4/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sansel Gardens of Memory</b>	23d. LOCATION (City, town, or county) (State) <b>Stoolkey Township, Illinois</b>
24. FUNERAL DIRECTOR <b>Maryanne Officer</b>		ADDRESS <b>2114 Missouri Avenue East St. Louis, Illinois</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 2 1963</b>
		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

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**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 Mariante. Offner

Licensed Embalmer No. 5177

P. O. Address 6. St. Louis, Ill.

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.