

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049068

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3560

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 2 1963

1. PLACE OF DEATH
 a. COUNTY St. Louis
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lemay Length of stay in 1b _____
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mt. St. Rose Hospital Inside Limits Yes No

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 No
 d. STREET ADDRESS (If outside, give location) 53 North Frisco Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
MINNIE MONTGOMERY
 4. DATE OF DEATH Month Day Year
December 5 1962

5. SEX female 6. COLOR OR RACE white 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 10/3/1905 9. AGE (last birthday) 57 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) at home 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) Davisville, Mo. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Phillip Anderson 13b. MOTHER'S MAIDEN NAME Minerva Dotson 14. NAME OF HUSBAND OR WIFE Troy A.

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. none 17. INFORMANT Troy A Montgomery Address 53 North Frisco

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH 7 yrs.?
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 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 NOT WHILE AT WORK 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 10-7-62 to 12-5-62 and last saw her alive on 12-4-62
 Death occurred at 3:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William A. Turner M.D. 22b. ADDRESS 4401 Hampton 22c. DATE SIGNED 12-6-62

23a. BURIAL, CREMATION, REMOVAL (Specify) removal 23b. DATE December 6 1962 23c. NAME OF CEMETERY OR CREMATORY St. Francois Memorial Park 23d. LOCATION (City, town, or county) (State) Bonne Terre, Missouri

24. FUNERAL DIRECTOR Murphy J. Sparks ADDRESS 31st River Mo 25. DATE RECD. BY LOCAL REG. 12-8-62 26. REGISTRAR'S SIGNATURE John B. Mumfley M.D.

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1961 8 NOV

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 Donald B. [Signature]

Licensed Embalmer No. 4863

P. O. Address [Signature]

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.