

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049121

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3660

FILED JAN 10 1963

VS 300
Rev. 4/59

1 4000

2 400X

3 2

4 1

5 2

6

7 0

8 2

9 332X

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11

12 86-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cool Valley		Length of stay in 1b 4 yrs	c. CITY OR TOWN Overland
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hilltop Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2714 Tennyson
3. NAME OF DECEASED (Type or print) First Anna Middle S Last Simpson		4. DATE OF DEATH Month Dec Day 15 Year 1962	
5. SEX Fe	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/13/1883
9. AGE (last birthday) 79		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St Louis Mo
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Walsh	
13b. MOTHER'S MAIDEN NAME Bridget Clark		14. NAME OF HUSBAND OR WIFE deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Albert Simpson Address 2417 Tennyson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 3 days
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) Generalized arteriosclerosis			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 May 24 - 1958 to Dec 15 - 1962 and last saw her alive on Dec 14 - 1962 Death occurred at 3 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John G. M. Finney MD (Degree or title)		22b. ADDRESS 5014 Thekla Av	22c. DATE SIGNED 12/15/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/18/1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cem	23d. LOCATION (City, town, or county) (State) St Louis Mo
24. FUNERAL DIRECTOR Ortmann F Home ADDRESS 9222 Lackland Overland Mo		25. DATE RECD. BY LOCAL REG. 12-15-62	26. REGISTRAR'S SIGNATURE [Signature]

USE BLACK INK OR TYPEWRITER RIBBON

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.