

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003323

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **313**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

| | | | | | |
|---|--|--|--|---|--|
| <p>FILED JAN 17 1963</p> | | <p>1. PLACE OF DEATH a. COUNTY Missouri</p> | | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY</p> | |
| <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. Louis</p> | | <p>Length of stay in 1b</p> | | <p>c. CITY OR TOWN ST. Louis</p> | |
| <p>c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp</p> | | <p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> | | <p>d. STREET ADDRESS (If outside, give location) 5926 Schulte</p> | |
| <p>3. NAME OF DECEASED (Type or print) First Mabel Middle Charlotte Last born.</p> | | <p>4. DATE OF DEATH Month 1 Day 10 Year 1963</p> | | | |
| <p>5. SEX Female</p> | | <p>6. COLOR OR RACE White</p> | | <p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p> | |
| <p>8. DATE OF BIRTH 6-28-1886</p> | | <p>9. AGE (last birthday) 76</p> | | <p>IF UNDER 1 YEAR Months Days Hours Min.</p> | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework</p> | | <p>10b. KIND OF BUSINESS OR INDUSTRY</p> | | <p>11. BIRTHPLACE (City and state or country) ILLINOIS</p> | |
| <p>12. CITIZEN OF WHAT COUNTRY USA</p> | | <p>13a. FATHER'S NAME John W. Crisp</p> | | <p>13b. MOTHER'S MAIDEN NAME Rose Salamon</p> | |
| <p>14. NAME OF HUSBAND OR WIFE Walter</p> | | <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO</p> | | <p>16. SOCIAL SECURITY NO. 153.0</p> | |
| <p>17. INFORMANT Address Anita Schwab 5926 Schulte</p> | | <p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) manition</p> | | <p>INTERVAL BETWEEN ONSET AND DEATH 5-6 years</p> | |
| <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) extensive spread of cancer through abdominal wall</p> | | <p>DUE TO (c) primary cancer of rectum.</p> | | | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> | | <p>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</p> | | | |
| <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> | | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p> | |
| <p>20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.</p> | | <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> | | <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p> | | <p>21. I attended the deceased from June 22nd 63 to January 10. 63 and last saw her alive on January 10. 63 Death occurred at 2:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.</p> | | | |
| <p>22a. SIGNATURE (Degree or title) Hermann Mads M.D.</p> | | <p>22b. ADDRESS 508 No. GRAND. AVE</p> | | <p>22c. DATE SIGNED 6.11.63</p> | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) Removal</p> | | <p>23b. DATE 1-12-63</p> | | <p>23c. NAME OF CEMETERY OR CREMATORY Memorial Park</p> | |
| <p>23d. LOCATION (City, town, or county) (State) ST. Louis Co MO</p> | | <p>24. FUNERAL DIRECTOR ADDRESS O'SULLIVAN-MUCKLE-KRON MORTUARY</p> | | <p>25. DATE RECD. BY LOCAL REG. JAN 11 1963</p> | |
| <p>26. REGISTRAR'S SIGNATURE Earl Smith M.D.</p> | | | | | |

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

64

Dr. Mass
metro 250

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

Albert Mayfield

Licensed Embalmer No.

03077

P. O. Address

St Louis Mo

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.