

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1213-63-003574
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED FEB 8 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>15 years</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4923 Theodore Avenue</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4923 Theodore Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Hay</u>			4. DATE OF DEATH Month Day Year <u>February 3 1963</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-1876</u>
9. AGE (last birthday) <u>86</u>		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) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>New York City, N.Y.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. NAME OF HUSBAND OR WIFE <u>deceased</u>	
13a. FATHER'S NAME <u>Samuel Dunn</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Murray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. [redacted]	
17. INFORMANT <u>Mrs. Almeda Latimer, 4923 Theodore Ave</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 da</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>332x</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerosis</u>			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 Month, Day, Year a.m. p.m.		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 <u>Feb 1 - 1963</u> to <u>Feb 3 - 1963</u> and last saw her alive on <u>Feb 3 - 1963</u>		Death occurred at <u>1:00 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>John G. McJannet M.D.</u>		22b. ADDRESS <u>5017 Sheela Av</u>	22c. DATE SIGNED <u>2/4/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 6, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>
24. FUNERAL DIRECTOR <u>Math Hermann & Son, Inc., 2161 E. Fair Ave St. Louis, 7, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 4 1963</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Stylford W. Barnley

Licensed Embalmer No. 4282

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.