

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009070

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1370

FILED FEB 19 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

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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 | | 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>y</u> yrs. | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3940 DeFonty Street,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>CHARLES</u> Last <u>MASTERS</u> | | | 4. DATE OF DEATH Month <u>February</u> Day <u>6,</u> Year <u>1963</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/25/95</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u> | 9. AGE (last birthday) <u>67 yrs.</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR |
| 11. BIRTHPLACE (City and state or country) <u>Milwaukee, Wisconsin</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Mrs. Estella Palmer Masters</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>005</u> | 17. INFORMANT <u>Mrs. Estella Masters, 3940 DeFonty Street</u> Address |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent carcinoma - terminal</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Post-op resection of carcinoma of hard palate</u> DUE TO (c) <u>144X</u> 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 type="checkbox"/> No <input type="checkbox"/> Unknown | | | INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u> <u>11 mos</u> |
| 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>July 1962</u> to <u>2/6/63</u> and last saw <u>her</u> alive on <u>2/6/63</u> Death occurred at <u>3:10 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Jessie A. Nishi, MD</u> | | 22b. ADDRESS <u>St Lukes Hosp</u> | 22c. DATE SIGNED <u>2/6/63</u> (State) |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Feb. 8, 1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Trinity Cemetery</u> | 23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Beiderwieden F.H.Inc., 1936 St. Louis (6)</u> | | 25. DATE RECD. BY LOCAL REG. <u>FEB 8 1963</u> | 26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u> |

USE BLACK INK OR TYPEWRITER RIBBON

Master

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 *David [unclear]*

Licensed Embalmer No. 4520
P. O. Address *[unclear]*

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.