

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009709

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 624

FILED MAR 5 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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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 <u>SUNSET SANITARIUM</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELLISVILLE MO</u>		Length of stay in 1b <u>2 MO</u>	c. CITY OR TOWN <u>KIRKWOOD MO</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SUNSET SANITARIUM</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>412 SARATOGA</u>
3. NAME OF DECEASED (Type or print) <u>CELOTILDE BASS</u>		First <u>CELOTILDE</u>	Middle <u>BASS</u>
4. DATE OF DEATH <u>Feb 21 1963</u>		Month <u>Feb</u>	Day <u>21</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COL</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>7-15-75</u>
9. AGE (last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u>2</u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>CARL BASS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CATHERINE LOCAS</u>		Address <u>412 SARATOGA</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>CHRONIC KIDNEY DISEASE</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Weeks 7 Months</u> <u>Long Term</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Generalized and Cerebral Arteriosclerosis with Arteriosclerotic Heart Disease</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 <u>3</u> Month, Day, Year <u>ERROR</u>			
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>December 13 '62</u> to <u>Feb 21, 1963</u> and last saw him alive on <u>Feb 14, 1963</u> . Death occurred at <u>4 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph J. Lauber, M.D.</u>		22b. ADDRESS <u>11745 Olive Street Road Crestwood, Mo.</u>	22c. DATE SIGNED <u>2/21/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-26-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PR. DICKSON</u>	23d. LOCATION (City, town, or county) (State) <u>CRESTWOOD MO.</u>
24. FUNERAL DIRECTOR <u>JOHN W. HEMPHILL</u>		ADDRESS <u>4085. FILLMORE</u>	25. DATE RECD. BY LOCAL REG. <u>2-25-63</u>
26. REGISTRAR'S SIGNATURE <u>John W. Hemphill, M.D.</u>			

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

Joseph E. Cooper

Licensed Embalmer No.

4600

P. O. Address

4648 St. Ferdinand

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.

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