

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-013186

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2926**

2926

FILED MAR 21 1963

VS 300
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

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | | | | | | |
|--|--|---|--|---|---|--|----------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 6 weeks | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1523 West Billon | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First FANNIE Middle BELLE Last DENISON | | | 4. DATE OF DEATH Month March Day 11 Year 1963 | | 5. SEX Female | | 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 4-15-1876 | | 9. AGE (last birthday) 86 | | 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) Cumberland Gap, Tenn. | | 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME James Lay | | 13b. MOTHER'S MAIDEN NAME Unknown | | |
| 14. NAME OF HUSBAND OR WIFE James C. Denison | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No | | 16. SOCIAL SECURITY NO. 331X | | 17. INFORMANT George W. Denison, Address above | | 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Cerebral Hemorrhage DUE TO (b) hypertension DUE TO (c) Arterio-sclerosis INTERVAL BETWEEN ONSET AND DEATH 44 days 4 or more years 5 or more years | | |
| 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 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 s.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 12/16/1950 to 3/11/1963 and last saw her/him alive on 3/10/63 Death occurred at 2:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) J.M. G. Traud MD | | |
| 22b. ADDRESS 1019 McCausland Ave. St. Louis, Mo. | | 22c. DATE SIGNED 3-12-63 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3-14-63 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Churchyard | | |
| 23d. LOCATION (City, town, or county) St. Louis Co., Mo. | | 24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo. | | 25. DATE RECD. BY LOCAL REG. MAR 13 1963 | | 26. REGISTRAR'S SIGNATURE Paul Smith, M.D. | | | | |

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 Melvin Barton

Licensed Embalmer No. 4903

P. O. Address St. Louis

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.