

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014162

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 874

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 18 1963

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN University City		c. CITY OR TOWN University City	
Length of stay in 1b 6 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Res. 6768 Bartmer		d. STREET ADDRESS (If outside, give location) 6768 Bartmer	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRIETTA SARAH FLETCHER			4. DATE OF DEATH March 10, 1963
First HENRIETTA Middle SARAH Last FLETCHER		Month March Day 10 Year 1963	
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1904
9. AGE (last birthday) 58 yrs		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Doniphan, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME George R. Dawes	
13b. MOTHER'S MAIDEN NAME Hanna S Lewis		14. NAME OF HUSBAND OR WIFE Charles R. Fletcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No None		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Mr. Charles R. Fletcher 6768 Bartmer		Address	
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH Sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 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: _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 24 Dec. 1962 to 10 March 1963 and last saw her ^{her} alive on 8 Mar. 1963 . Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul N. Wagness M.D. (Degree or title)		22b. ADDRESS University City, Mo	
22c. DATE SIGNED 11 Mar. '63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 13, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)
24. FUNERAL DIRECTOR ALEXANDER & SONS TOWN CHAPEL 6175 Delmar ADDRESS		25. DATE RECD. BY LOCAL REG. 3-11-63	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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Rev. 4/59

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24006

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USE BLACK INK OR TYPEWRITER RIBBON

O. G. Magness

STATE OF MISSISSIPPI

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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 J. Allen Davis Jr
Licensed Embalmer No. 4053

P. O. Address Monticello, Miss 38756

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.