

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-014453

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 738

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED MAR 18 1963		1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jennings</u>		Length of stay in 1b		c. CITY OR TOWN <u>Bissell Hills</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>High Towers Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>304 Mid Ridge Dr</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bert</u> Middle <u>TOWNSEND</u> Last <u>Sr</u>			4. DATE OF DEATH Month <u>3</u> Day <u>-1-</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>Oct 16 1887</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kiln Burner (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo Part Cement</u>		11. BIRTHPLACE (City and state or country) <u>Neelyville Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		13a. FATHER'S NAME <u>Frank Townsend</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>	
14. NAME OF HUSBAND OR WIFE <u>Hallie</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. <u>[Redacted]</u>	
17. INFORMANT <u>Bert Townsend Jr</u>		Address <u>13 Jendale Ct</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral malaria</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular d</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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	
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 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>Sept 19, 1961</u> to <u>Mar 1, 1963</u> and last saw him alive on <u>Feb 25, 1963</u> Death occurred at <u>9:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Lewis Littmann MD</u> (Degree or title)			22b. ADDRESS <u>8231 Clayton Rd (17)</u>		22c. DATE SIGNED <u>3/2/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-4-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>O'SULLIVAN-MUCKLE-KRON, MORTUARY</u> <u>8806 JENNINGS ROAD</u>			25. DATE RECD. BY LOCAL REG. <u>3-2-63</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy</u>

Lewis Bettman
8731 Clayton Road
Pa 70302
Je 35458

DEPT. OF HEALTH

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 Albert Madfield

Licensed Embalmer No. 3077

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.