

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017602

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4246

FILED APR 23 1963

VS 300
Rev. 4/59

1

2 203

3

4 1

5 3

6

7 1

8 1

9

10

11

12 52-0

13

STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2836 WATSON</u>				Reside on Farm: Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>C.</u> Last <u>FANNEN</u>						4. DATE OF DEATH Month <u>APRIL</u> Day <u>16</u> Year <u>1963</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>NOV 29 1899 63</u>		9. AGE (last birthday) <u>63</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK WOOD TREATING CHEM CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STAUNTON ILL</u>		11. BIRTHPLACE (City and state or country) <u>U-S-A</u>		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME <u>MARTIN WEISSEN BORN</u>				13b. MOTHER'S MAIDEN NAME <u>MARY MAI</u>				14. NAME OF HUSBAND OR WIFE <u>LEONA BERRY 9611 REAVES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date) <u>No</u>						16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>LEONA BERRY 9611 REAVES</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>Carcinoma of cervix</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>171X</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>12/11/60</u> to <u>4/16/63</u> and last saw her <u>alive</u> on <u>4/16/63</u> Death occurred at <u>5:20</u> <u>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>[Signature]</u> M.D.						22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>4/16/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		STATE			
<u>REMOVAL</u>		<u>APR 18 1963</u>		<u>MEMORIAL PARK</u>		<u>STAUNTON ILL.</u>		<u>ILL.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>APR 17 1963</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u> M.D.					

52

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. A. Humphrey

Licensed Embalmer No. 4772

P. O. Address 2906 Graves

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.