

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-018024

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4049

FILED APR 17 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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24009-3
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.: SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

One Hospital 22 hrs

1. PLACE OF DEATH a. COUNTY		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) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>2 Days</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>37 N. Clark Ave.</u>	
3. NAME OF DECEASED (Type or print): <u>Julia Nolte</u>		4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>63</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11a. FATHER'S NAME <u>Charles G. Wilson</u>		11b. MOTHER'S MAIDEN NAME <u>Emma A. Williams</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		12b. SOCIAL SECURITY NO. <u>None</u>	
13a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>		13b. INTERVAL BETWEEN ONSET AND DEATH <u>unk</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u>		DUE TO (c) <u>4200</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Gastro Intestinal Hemorrhage</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.) <u>---</u>	
20c. TIME OF INJURY Hour <u>---</u> a.m. <u>---</u> 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.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>
21. I attended the deceased from <u>April 8-63</u> to <u>Apr 9-63</u> last saw her alive on <u>Apr 9-63</u> Death occurred at <u>2:05 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Sheep Swanner M.D.</u>	
22b. ADDRESS <u>1115 Paul Brand Blvd. St. Louis</u>		22c. DATE SIGNED <u>Apr 10-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-11-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem Lutheran Cemetery</u>	23d. LOCATION (City, town, or county) <u>Black Jack Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>White-Mullen 118 N. Florissant Rd. Ferg.</u>		25. DATE RECD. BY LOCAL REG. <u>APR 10 1963</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

OK Helen P. Taylor 4-10-63

Mr Robert Warner
Daniel Brown Bell
Ch. 1-4747
5071 Donovan

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 _____ Signed Reinhold K. Lohmann
Signature of Student Embalmer

Licensed Embalmer No. 3395

P. O. Address St Louis 35 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.