

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022006

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4934** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 17 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3668 Bellerive				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3668 Bellerive				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Agnes A. Murray						4. DATE OF DEATH Month Day Year May 7, 1963					
5. SEX female		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-7-71		9. AGE (last birthday) 92		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME David R. Bayles				13b. MOTHER'S MAIDEN NAME Ann McCabe				14. NAME OF HUSBAND OR WIFE James Murray			
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.				17. INFORMANT St. Louis, Mo. Oscar Laaker 3668 Bellerive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene, Right Leg.										INTERVAL BETWEEN ONSET AND DEATH 6-8 mo	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis										year	
DUE TO (c) Infirmitie of Age										-	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 450.1								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 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 November 1962 to May 7/63 and last saw her alive on May 6/63 Death occurred at 3 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Edward J. Jordan MD						22b. ADDRESS 1504 South Grand			22c. DATE SIGNED May 7/63		
23a. BURIAL, CREMATION, OR DATE REMOVAL (Specify) 5-9-63				23c. NAME OF CEMETERY OR CREMATORY St. DeSales Cem.				23d. LOCATION (City, town, or county) (State) Burnside, Ill.			
24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand Blvd				25. DATE RECD. BY LOCAL REG. MAY 7 1963		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.					

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

~~Mr. Pites~~

Mr. Jordan

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

Not Autopsied

Signed *James C. Will*

Licensed Embalmer No. *4347*

P. O. Address *6322 So Grand*

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.