

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025850

DO NOT WRITE ON THIS SUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6532**

STATE FILE NUMBER

FILED JUN 28 1963

1. PLACE OF DEATH a. COUNTY		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 St. Louis		Length of stay in 1b	c. CITY OR TOWN Webster Groves Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 805 Greely Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Florence Middle Lenora Last Favre			4. DATE OF DEATH Month June Day 20 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 11/9/10	9. AGE (last birthday) 52	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and state or country) Paducah, Kentucky		12. CITIZEN OF WHAT COUNTRY USA.
13a. FATHER'S NAME James B. Jones		13b. MOTHER'S MAIDEN NAME Cora M. Howard		14. NAME OF HUSBAND OR WIFE Rene W. Favre		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Address Rene W. Favre, 805 Greely Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNKNOWN - SUSPECTED Pulmonary Embolus		INTERVAL BETWEEN ONSET AND DEATH.
DUE TO (b) Rheumatic Heart Disease		
DUE TO (c) Mitral Stenosis & Mitral Insufficiency		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Hypertension, Congestive Ht. Failure		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	
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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.) 410x	
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20c. TIME OF INJURY Hour 1:00 a.m. p.m. PM Month, Day, Year 6-20-63	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 St. Louis	COUNTY St. Louis	STATE Mo.
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21. I attended the deceased from **5/29/63** to **6-20-63** and last saw her/him alive on **6-20/63**
Death occurred at **1:00 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John R. Schafroth MD (Degree or title)	22b. ADDRESS Firmin Desloge Hospital	22c. DATE SIGNED 6/21/63 (Date)
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 6/24/63	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) St. Louis County Missouri
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24. FUNERAL DIRECTOR Parker-Aldrich, Webster Groves, Mo	25. DATE RECD. BY LOCAL REG. JUN 21 1963	REGISTRAR'S SIGNATURE Roan Smith, M.D.
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USE BLACK INK OR TYPewriter RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Hebster Groves, 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.