

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026141

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7012** STATE FILE NUMBER

FILED JUL 12 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59
 1
 2 205
 3
 4 /
 5 ?
 6
 7 /
 8 /
 9
 10
 11
 12 75-0
 13
 75
 Martin P. Stein, M.D.
 USE BLACK INK OR TYPEWRITER RIBBON
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5878 Cabanne Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADA Middle Bell Last Mc GUIRE			4. DATE OF DEATH Month 7 Day 2 Year 63		5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		
8. DATE OF BIRTH 9/8/1884		9. AGE (last birthday) 78		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) Texas		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME John William Morgan				13b. MOTHER'S MAIDEN NAME Mattie Hill				14. NAME OF HUSBAND OR WIFE James A. McGuire			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No						17. INFORMANT Address Deronda Gazzola, 5878 Cabanne 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) Pneumonia due to unknown organism DUE TO (b) Organism DUE TO (c) 491x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rheumatic heart disease, inactive								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 6/29/63 to 7/2/63 and last saw her/him alive on 7/2/63 Death occurred at 10:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE M. P. Stein MD (Degree or title)						22b. ADDRESS 1515 LAFAYETTE AVE.			22c. DATE SIGNED 7/2/63		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-6-63		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				23d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd,						25. DATE RECD. BY LOCAL REG. JUL 5 1963		26. REGISTRAR'S SIGNATURE Joan Smith, M.D.			

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. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address A. 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.

Embalmer