

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029595

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 430a

FILED JUL 22 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Saint Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Charles</u>			Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Rural- Puruque twsp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>St. Paul</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Cecilia</u>			First <u>M.</u> Middle <u>Vehige</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>18</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1890</u>		9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own</u>		11. BIRTHPLACE (City and state or country) <u>Old Monroe, Missouri</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Henry A. Burkemper</u>				13b. MOTHER'S MAIDEN NAME <u>Christina Ball</u>				14. NAME OF HUSBAND OR WIFE <u>Henry Vehige</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>				16. SOCIAL SECURITY NO. <u>409</u>		17. INFORMANT <u>Leander Vehige, St. Paul, Missouri</u>							
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>								Unknown					
DUE TO (c)													
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 type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input 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 <u>2:40</u> 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>July 16, 1963</u> to <u>July 18, 1963</u> and last saw her alive on <u>July 17, 1963</u> Death occurred at <u>2:40 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Eugene J. Canty, M.D.</u> (Degree or title)						22b. ADDRESS <u>St. Charles, Mo</u>			22c. DATE SIGNED <u>July 19, 1963</u> (State)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 20, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>			23d. LOCATION (City, town, or county) <u>St. Paul, Missouri</u> (State)						
24. FUNERAL DIRECTOR <u>Keithly-Davis, Inc., O'Fallon, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>July 19-1963</u>		26. REGISTRAR'S SIGNATURE <u>Mabel Zumwalt Dep</u>							

USE BLACK INK OR TYPEWRITER RIBBON

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 James R. Amador

Licensed Embalmer No. 4832

P. O. Address St. Charles, 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.

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