

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029727

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7909 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 9 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
		St Louis				Mo.				St Louis		Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
Parkside Manor						4632 Tower Grove Pl.				Yes <input type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		5. MONTH		6. DAY		7. YEAR					
First Middle Last						Aug.		2		1963							
8. SEX		9. COLOR OR RACE		10. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		11. DATE OF BIRTH		12. AGE (last birthday)		13. IF UNDER 1 YEAR		14. IF UNDER 24 HR					
Female		White				10/2/76		86		Months Days		Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY					
At home								St Louis Mo.				USA					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE									
Jacob Miller				Unknown				George E.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
No								George J Brenner				5642 Rosa					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a)												2 days					
DUE TO (b) <i>metastatic carcinoma of liver</i>												6 mo					
DUE TO (c) <i>Primary site unknown</i>																	
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.					
												1562					
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. 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>1961</u> to <u>1963</u> and last saw her <u>8/2/63</u> alive on <u>8/2/63</u> . Death occurred at <u>7 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title)						22b. ADDRESS				22c. DATE SIGNED (State)							
<i>Durston A. Smith M.D.</i>						<i>4632 Maryland</i>				<i>8/3/63</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				STATE					
Cremation		8/3/63		Hillcrest Abbey				St Louis				Mo. Lr.					
24. FUNERAL DIRECTOR ADDRESS						25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE									
John L Ziegenhein & Sons 7027 Gravois						AUG 3 1963		<i>Roald Smith, M.D.</i>									

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 E. P. Kedwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.