

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037422

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9863**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS:300
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		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															
OCT 10 1963		St. Louis		6 days		Mo.		St. Louis															
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 checked="" type="checkbox"/>															
Missouri-Baptist Hospital		Yes <input type="checkbox"/> No <input type="checkbox"/>		114 Nellie ave.																			
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year														
Minnie Louise Casper						October 1 1963																	
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR											
Female		White				9-5-1895		68		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											
Housewife				Own Home				St. Louis, Mo.				U S A											
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
Unknown Baumann				Louise last name unknown				David															
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								David Casper				114 Nellie ave. Lemay, Mo.											
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)																							
Metastatic Adeno Carcinoma																							
Primary (?)																							
DUE TO (b)																							
Pulmonary Insufficiency due to																							
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.											
199.2												<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		SUICIDE		HOMICIDE		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 <u>Sept 25</u> to <u>Oct 1, 1963</u> and last saw her <u>alive</u> on <u>Oct 1</u> .																							
Death occurred at <u>1.30 P.M.</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											
<u>E. H. Demwick M.D.</u>						<u>453 N. Taylor</u>						<u>10/3/63</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)											
Removal				10-4-1963				Park Lawn Cemetery				1600 Lemay Ferry Road Lemay, Mo.											
24. FUNERAL DIRECTOR						ADDRESS						25. DATE RECD. BY LOCAL REG:						26. REGISTRAR'S SIGNATURE					
C. Hoffmeister Mortuaries						7814 S. Broadway						OCT 3 1963						Roan Smith, M.D.					

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 John L. Penneby
Licensed Embalmer No. 4194
P. O. Address St. 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.

Dr. Everett S. Klemmick on funeral
453 N. Douglas
For - 1604