

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042290

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3100

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 30 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1 4022						
2 17140						
3						
4 1						
5 2						
6						
7 0						
8 2						
9 334XH						
10						
11 1286-0						
13						
ITEM NO.	SHOULD READ					

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY AUDRAIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ELLISVILLE		Length of stay in 1b 4^{1/2} MONTHS	c. CITY OR TOWN LADDONIA Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SUNSET SANITARIUM		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) NONE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edna Middle EUGENIA Last HALL		4. DATE OF DEATH Month OCTOBER Day 7 Year 1963	
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 12/13/1882
9. AGE (last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days 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 NONE	11. BIRTHPLACE (City and state or country) LADDONIA, MISSOURI
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME JOHN A. SMITH	
13b. MOTHER'S MAIDEN NAME JESSIE GRAY		14. NAME OF HUSBAND OR WIFE JAMES HALL	
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. NONE	17. INFORMANT 802 NIRK, KIRKWOOD 22, MISSOURI GERALDINE STEUBER
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular insufficiency - acute			INTERVAL BETWEEN ONSET AND DEATH 3 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis			10 yrs.
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) granulocytic leukemia, arteriosclerotic heart disease.			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 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. 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 April 14 1963 to Oct 7 1963 and last saw her ^{her} _{him} alive on Oct. 6, 1963 Death occurred at 8:30 P on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W.B. Medney M.D.		22b. ADDRESS 806 Annapolis St. N. Valley Park, Mo.	22c. DATE SIGNED Oct 8, 1963
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10/10/63	23c. NAME OF CEMETERY OR CREMATORY VANDALIA CEM.	23d. LOCATION (City, town, or county) (State) VANDALIA, MISSOURI
24. FUNERAL DIRECTOR WILKEY BIENHOFF, LADDONIA, MISSOURI	ADDRESS	25. DATE RECD. BY LOCAL REG. 10-9-63	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

USE BLACK INK OR TYPEWRITER RIBBON

013510-0125

STATE OF MICHIGAN

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

Ben E. Hoffman

Licensed Embalmer No. _____

P. O. Address _____

*4366
E. Toussaint Ave.*

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.