

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045960

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11885**

STATE FILE NUMBER

FILED DEC 5 1963

VS 300  
Rev. 4/59

1

2 *21*

3

4 *1*

5 *2*

6

7 *0*

8 *2*

9

10

11

12 *86-0*

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>1 Mo.</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Stone Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4375 West Pine</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>C.</b> Last <b>Roch</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> Year <b>1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-6-80</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (last birthday) <b>83</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11a. FATHER'S NAME <b>Michael Winters</b>		11b. MOTHER'S MAIDEN NAME <b>Eva Donius</b>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		12b. INFORMANT <b>William E. Roch, 6040 Marquette</b> Address	
13a. FATHER'S NAME <b>Michael Winters</b>		13b. MOTHER'S MAIDEN NAME <b>Eva Donius</b>	
14a. FATHER'S NAME <b>Michael Winters</b>		14b. MOTHER'S MAIDEN NAME <b>Eva Donius</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. INFORMANT <b>William E. Roch, 6040 Marquette</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, suspected</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Pulmonary emphysema</b>			<b>52-71</b> <b>5+ years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Severe general atherosclerosis, atherosclerotic heart disease, cerebral atherosclerosis</b>			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 <b>October 1963</b> to <b>Nov. 30, 1963</b> and last saw her/him alive on <b>Nov. 29, 1963</b> Death occurred at <b>11:45 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John D. Vavra, M.D.</b> (Degree or title)		22b. ADDRESS <b>440 Melville, St. Louis 30, Mo.</b>	
22c. DATE SIGNED <b>Dec. 2 1963</b> (State)		22d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>12-3-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
24. FUNERAL DIRECTOR <b>Drehmann-Harral, 1905 Union Blvd.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>DEC 2 1963</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>

Dr. Vavra  
Barnes Hospital

11-5-08

0-08

**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 Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address \_\_\_\_\_

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.