

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-046027

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11303**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 22 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in lb		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		Affton		Reside on Farm 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"/>					
St. John's Hospital						9917 Gravois									
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year			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"/>			
MARY KATHERINE SELZ			Nov. 14 1963			Female			White			8. DATE OF BIRTH 8-2-1924			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			9. AGE (last birthday)			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HR Hours Min.			
Housework			At Home			39						U.S.A.			
11a. BIRTHPLACE (City and state or country)				11b. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY							
St. Louis, Mo.				St. Louis, Mo.				U.S.A.							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
William Hanewinkel				Katherine Julius				Leroy W. Selz							
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				None				Leroy W. Selz 9917 Gravois							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												INTERVAL BETWEEN ONSET AND DEATH			
Cerebral Hemorrhage												7 days			
DUE TO (b)															
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 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 9 Nov 63 to 14 Nov 63 and last saw her alive on 14 Nov 63 Death occurred at 6:55 P. m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) John F. McLean M.D.						22b. ADDRESS 4401 Hampton			22c. DATE SIGNED 15 Nov 63						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE Nov. 18, 1963		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery			23d. LOCATION (City, town, or county) St. Louis Co. Mo.			23e. STATE Mo.				
24. FUNERAL DIRECTOR Kriegshausner 4228 S. Kingshighway Blvd.						25. DATE RECD. BY LOCAL REG. NOV 15 1963			26. REGISTRAR'S SIGNATURE Roal Smith M.D.						

VS 300
Rev. 4/59

1
2 **4000-3A**
3
4
5
6
7
8
9
10
11
12 **74-0**
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

74

Dr. John McCann Hu. 1-8118
4401 Hampton Ave. 12-3

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 Edwin A. McAnneth

Licensed Embalmer No. 3024

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.