

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046507

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3775

FILED DEC 16 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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28130

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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

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILL</u> b. COUNTY <u>LA SALLE</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>DES PERES</u>		Length of stay in 1b <u>10 days</u>	c. CITY OR TOWN <u>OTTAWA</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CHASTAIN'S, INC</u>		Inside Limits Yes <input checked="" 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"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN LAWRENCE MURDOCK</u>			4. DATE OF DEATH Month Day Year <u>DEC. 10 1963</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	9. AGE (last birthday) <u>79</u> IF UNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME <u>FRED F. LAWRENCE</u>		11b. MOTHER'S MAIDEN NAME <u>MARY ROBBINS WOODS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>NO</u>		16. SOCIAL SECURITY NO.	14. NAME OF HUSBAND OR WIFE <u>-</u>
17. INFORMANT <u>LAWRENCE MURDOCK</u>		Address <u>815 Old Elm Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> <u>Metastasis to Brain</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
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 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 <u>1940</u> to <u>12/10/63</u> and last saw her <u>alive</u> on <u>12/10/63</u> Death occurred at <u>6:35</u> P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul D Brand MD</u>		22b. ADDRESS <u>Webster Groves Mo</u>	22c. DATE SIGNED <u>12/18/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12/13/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OTTAWA AVE. CEMETERY</u>	23d. LOCATION (City, town, or county) <u>OTTAWA, ILLINOIS</u>
24. FUNERAL DIRECTOR <u>MITTELBERG GERBER</u> ADDRESS <u>COLONIAL CHAPEL</u>		25. DATE RECD. BY LOCAL REG. <u>12-11-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u>

1-1-1918

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**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 Harry E. Monroe

Licensed Embalmer No. 4495

P. O. Address St. Louis

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.