

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049969

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **12740**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 6 1964

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		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
		St Louis				MO				St Louis		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"/>			
Incarnate Word Hospital						3517 Michigan							
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH Month Day Year			
Anna				Smith						Dec. 22 1963			
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR	
Female		White				1/22/90		73		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			
Housework Domestic								Ohio		USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE					
Rudolph Sturm				Unknown				George Smith (Dec)					
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								William Unwin 9814 Chesterton					
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) Carcinoma of Colon with metastases												6 mos	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
DUE TO (b) underpneumonia, liver, lungs, lymph nodes etc.													
DUE TO (c) 153.8													
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.					
Gen Arteriosclerosis, Arteriosclerotic Heart Disease								<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>Nov 15 1963</u> to <u>Nov</u> and last saw her <u>alive</u> on <u>12/21/63 10 AM</u> Death occurred at <u>4:45 AM Dec 22 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Doan L. Ramsey M.D.</u>						22b. ADDRESS <u>3201(4) So. Grand Blvd, City</u>		22c. DATE SIGNED <u>12/22/63</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)					
Removal		Dec. 24 63		Memorial Park Cem.		St. Louis County		Mo.					
24. FUNERAL DIRECTOR <u>Thomas Latis 2906 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>DEC 24 1963</u>		26. REGISTRAR'S SIGNATURE <u>Doan Smith M.D.</u>							

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

VS 300
Rev. 4/59

1

2 9/16

3

4 1

5 3

6

7 1

8 1

9

10

11

12 63-0

13

63

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 J. A. Heraphy

Licensed Embalmer No. 4772

P. O. Address 2906 Lewis

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. Ramona
32015 J. Stewart
Dr. 22222