

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050307

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3873

FILED JAN 3 1964

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u> Length of stay in 1b <u>7 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>St. John</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>9415-NORTH AVE.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Belle</u> Middle <u>Meyers</u> Last <u>Meyers</u> 4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>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>2-17-1878</u> 9. AGE (last birthday) <u>85</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>Home</u> 11. BIRTHPLACE (City and state or country) <u>Palmira, Ill.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Frank Crawford</u> 13b. MOTHER'S MAIDEN NAME <u>Edwina</u> 13c. NAME OF HUSBAND OR WIFE <u>Edward</u> 14. ADDRESS <u>8940 St. Charles Rd.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u> 17. INFORMANT <u>Carl Meyers</u> Address <u>8940 St. Charles Rd.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Left Ventricular failure</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>4.5 days</u> <u>Unknown</u>	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Probable Retief urine mass in abdomen</u>		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		
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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 checked="" 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 12-11-1963 to 12-18-1963 and last saw her ^{her} _{him} alive on 12-18-1963
 Death occurred at 7:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Thelma J. Albert M.D.</u>		22b. ADDRESS <u>601 S. Brentwood, Clayton 5</u>		22c. DATE SIGNED <u>12/19/63</u> (State)	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-20-1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEM.</u>		23d. LOCATION (City, town, jar. county) <u>St. Louis, Mo.</u>	
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24. FUNERAL DIRECTOR ADDRESS <u>William Breda Inc. 2504-1/2 Woodson Rd. Overland, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-19-63</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59	
1 <u>4002</u>	
2 <u>4039</u>	
3 <u>2</u>	
4 <u>1</u>	
5 <u>2</u>	
6	
7 <u>1</u>	
8 <u>2</u>	
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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 David C. Gibson

Licensed Embalmer No. 3454

P. O. Address St. L. 14 Mo.

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.

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