

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 3 4 1

FILED VS DEC 3 0 1959

STATE FILE NUMBER

211266

Registration District No. Primary Registration District No. Registrar's No.

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN Affton		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9023 Kathleen			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Betty Cozean			4. DATE OF DEATH Month Day Year December 2 1959				
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/30/1910	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Newport, Arkansas	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Clarence Ray			13b. MOTHER'S MAIDEN NAME Berlin Lumby		14. NAME OF HUSBAND OR WIFE Hugh		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.	17. INFORMANT Address Hugh Cozean 9023 Kathleen			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute brain edema</i> <i>diffuse astrocytoma</i> DUE TO (b) <i>Diffuse astrocytoma</i> DUE TO (c) <i>193.0</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>probably years.</i>
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 <i>25 Nov 59</i> to <i>2 Dec 59</i> and last saw her <sup>her</sup> <sub>him</sub> alive on <i>1 Dec 1959</i> Death occurred at <i>2 Dec 1959 9:00 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>J.P. Schearff</i> (Degree or title) <i>J. P. Schearff, M.D.</i>				22b. ADDRESS <i>6540 Chippewa</i>			22c. DATE SIGNED <i>12-3-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 12/5/1959	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)	
24. FUNERAL DIRECTOR ADDRESS John L Ziegenhein & Sons 7027 Gravois			25. DATE RECD. BY LOCAL REG. DEC 5 1959		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> <i>mrb</i>		

DOCUMENT

MEDICAL CERTIFICATION

Site: frontal lobe brain  
BY AFFIDAVIT OF

**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 Donald E. Reiz

Licensed Embalmer No. 4863

P. O. Address St. Louis, 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.