URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008189

FILED VS FEB 25 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1507

NDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: DePaul Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Florissant
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 170 Cortez Drive
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Janice Middle: Marie Last: Ferris

4. DATE OF DEATH: Month February Day 8 Year 1960

5. SEX: female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-20-59
9. AGE (last birthday): IF UNDER 1 YEAR: Months 11 Days 16 IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: James Ferris
13b. MOTHER'S MAIDEN NAME: Florence Weeks
14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: James Ferris Address: 170 Cortez Drive

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Gastroenteritis & Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 571.0

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. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 ☐ NOT WHILE AT WORK ☐
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 11PM 2/7/60 to 2/8/59 and last saw her/him alive on 2/8/60
Death occurred at 8:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Burch A. Merritt M.D.
22b. ADDRESS: 7309 Natural Bridge
22c. DATE SIGNED: 2/9/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-10-1960
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery
23d. LOCATION (City, town, or county) (State): Normandy, Missouri

24. FUNERAL DIRECTOR: Baumann Bros. Inc. ADDRESS: 2504 Woodson Rd. Overland, Mo.
25. DATE RECD. BY LOCAL REG.: FEB 9 1960
26. REGISTRAR'S SIGNATURE: Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed David C. Gibe

Signature of Student Embalmer

Licensed Embalmer No. 3454

P. O. Address Overland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.