

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012666

FILED VS. APR 12 1960

Primary Registration District No. _____

Registrar's No. **2 3472**

STATE FILE NUMBER

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN Ferguson 34 | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital | | d. STREET ADDRESS (If outside, give location) 500 Ames | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELLEN MARIE HALL | | 4. DATE OF DEATH Month Day Year 3 - 27 - 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3-27-60 |
| 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) St. Louis, Mo. |
| 13a. FATHER'S NAME ALVIN HALL | | 13b. MOTHER'S MAIDEN NAME CAROL MOHL | 14. NAME OF HUSBAND OR WIFE 500 Ames |
| 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 Ms Carol Hall 500 Ames |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial | | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 325.4 | | | |
| 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 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 Month, Day, Year a.m. p.m. | | | |
| 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 3/27/60 to 3/27/60 and last saw her live on 3/27/60 Death occurred at 6:00 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Jack T. Steele, M.D. (Declarant title) | | 22b. ADDRESS 40 W. Florissant | 22c. DATE SIGNED 3/27/60 (State) |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-28-60 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cem. | 23d. LOCATION (City, town, or county) St. Louis, Mo. |
| 24. FUNERAL DIRECTOR John Stygar & Son ADDRESS 5541 Riverview | | 25. DATE RECD. BY LOCAL REG. MAR 28 1960 | 26. REGISTRAR'S SIGNATURE Carol Smith, M.D. |

DOCUMENT

MEDICAL CERTIFICATION

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

JMR

Licensed Embalmer No. 3980

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.