

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 12 1960

60-012791

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3578** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		a. STATE MISSOURI b. COUNTY	
Length of stay in 1b		c. CITY OR TOWN ST LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1		d. STREET ADDRESS (If outside, give location) 1802 S. JEFFERSON	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARGARET Middle JUDY Last			4. DATE OF DEATH Month March Day 29 Year 1960		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/10/1868	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months 9 Days 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		10b. KIND OF BUSINESS OR INDUSTRY KLINE'S DEPT STORE		11. BIRTHPLACE (City and state or country) UNKNOWN	
12. CITIZEN OF WHAT COUNTRY U. S. A		13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE WILLIAM H. JUDY (LATE)		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. No	
17. INFORMANT MRS ADA HESS		Address 1802 S. JEFFERSON			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium due to coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) chronic DUE TO (c) Carcinoma - of Left Lung		
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 **3/23/60** to **3/29/60** and last saw ^{her} _{him} alive on **3/29/60**
Death occurred at **7:05 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Paul J. Stein, M.D.		22b. ADDRESS 1515 Lafayette Ave.		22c. DATE SIGNED 3/29/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 3-30-60		23c. NAME OF CEMETERY OR CREMATORY VIAHALLA CREM.	
23d. LOCATION (City, town, or county) (State) ST. LOUIS		24. FUNERAL DIRECTOR LUPTON'S		25. DATE RECD. BY LOCAL REG. MAR 29 1960	
24. ADDRESS 7233 DELMAR		26. REGISTRAR'S SIGNATURE Earl 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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.