

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016525

FILED VS APR 26 1960

316 Primary Registration District No. 3059 Registrar's No. 157

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. FRANCOIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. FRANCOIS</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>BONNE TERRE</b>		Length of stay in 1b <b>12 DAYS</b>		c. CITY OR TOWN <b>FARMINGTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BONNE TERRE HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>512 STE. GENEVIEVE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CATHERINE HENRIETTA PHELPS</b>				4. DATE OF DEATH Month Day Year <b>APRIL 22 1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-4-1890</b>	9. AGE (last birthday) <b>69</b>	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) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOSEPH KLEINE</b>			13b. MOTHER'S MAIDEN NAME <b>MARY SCHAEFFER</b>		14. NAME OF HUSBAND OR WIFE <b>FRED PHELPS</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MARIE PHELPS WEINGARTEN, MO.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerosis Heart Dis.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <b>Diabetes mellitus - gangrene of left leg.</b>					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 Month, Day, Year s.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 <b>Apr 11, 1960</b> to <b>Apr 21, 1960</b> and last saw her <sup>her</sup> alive on <b>Apr 21, 1960</b> Death occurred at <b>5:30/A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>R.A. Huckstep M.D.</b>				22b. ADDRESS <b>Farmington, MO.</b>		22c. DATE SIGNED <b>4/23/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>APRIL 25, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY</b>		23d. LOCATION (City, town, or county) <b>ST. LOUIS, MO.</b>		(State)
24. FUNERAL DIRECTOR ADDRESS <b>C. H. COZEAN FARMINGTON, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>Apr 23, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Ether Redloff</b>	

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. 408

P. O. Address Ferry

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