

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020700

FILED VS MAY 25 1960

318

Primary Registration District No. 1003

Registrar's No. 5248

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		c. CITY OR TOWN <b>ST. LOUIS, MO</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		d. STREET ADDRESS (If outside, give location) <b>2335 WHITTEMORE</b>	
Inside Limits 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) <b>MARY</b>	First	Middle <b>ALICE</b>	Last <b>BOLTON</b>	4. DATE OF DEATH <b>MAY 12, 1960</b>	Month	Day	Year
--	-------	------------------------	-----------------------	---	-------	-----	------

5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/60</b>	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Mins.
-------------------------	----------------------------------	---	------------------------------------	------------------------	--------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</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>CARL ALONZO BOLTON</b>	13b. MOTHER'S MAIDEN NAME <b>HELEN IRENE HALL</b>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

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>no</b>	17. INFORMANT <b>ST. LOUIS CITY HOSP. #1.</b>	Address
---	--------------------------------------	--	---------

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>Immaturity</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>762.5</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Lungs, partial atelectasis</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 checked="" type="checkbox"/> NO <input 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 <b>ST. LOUIS, MO</b>	COUNTY	STATE
---	--	--	--	--------	-------

21. I attended the deceased from <b>5/12/60</b> to <b>5/12/60</b> and last saw her him alive on <b>5/12/60</b> Death occurred at <b>10:30 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE <b>Welda Clasen, M.D.</b>	(Degree or title)	22b. ADDRESS <b>1515 LAFAYETTE AVE</b>	22c. DATE SIGNED <b>5/12/60</b>
---	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>MAY 31 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
---	---------------------------------	---	--

24. FUNERAL DIRECTOR <b>Rowland Mortuary Svc. 4104-05 Manchester</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>MAY 19 1960</b>	26. REGISTRAR'S SIGNATURE <b>Leon Smith, M.D.</b>
---	---------	--	--

DOCUMENT

MEDICAL CERTIFICATION

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.