

JURISDICTION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025204

FILED **VS JUN 22 1960**

317

Primary Registration District No. **541**

Registrar's No. **1717**

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Length of stay in 1b 3 days	c. CITY OR TOWN St. Louis Clayton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6401 Alamo Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Grace Field			4. DATE OF DEATH Month Day Year May 31, 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 Dec. 25, 1876
9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR 83 Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U S A
13a. FATHER'S NAME Joseph Mansfield		13b. MOTHER'S MAIDEN NAME Elizabeth Clayton	14. NAME OF HUSBAND OR WIFE Thomas
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. None	17. INFORMANT Address Mrs. Laura Dodson 618 Kayser St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac sufficiency due to A.S.H.O. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Low Neck fracture left femur DUE TO (c) Pneumonia			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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. 7:00 5-28-60	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) Home	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 5-28-60 to 5-31-60 and last saw her alive on 5-31-60 Death occurred at 11:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wilroy L. Hunt M.D.		22b. ADDRESS 6015 Brentwood, Clayton, Mo.	22c. DATE SIGNED 5/31/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 3, 1960	23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery	23d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Rd. Lemay, Mo.
24. FUNERAL DIRECTOR ADDRESS C. Hornelster Mortuaries 7814 S. Broadway		25. DATE RECD. BY LOCAL REG. 6-1-60	26. REGISTRAR'S SIGNATURE J. B. W. [Signature]

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 John Shenn

Licensed Embalmer No. 4194

P. O. Address St. Louis

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.