

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028413

FILED VS AUG 8 1960

318

Primary Registration District No. 1003

Registrar's No. 7513

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>26 Yrs.</b>		c. CITY OR TOWN <b>St. Louis</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>1390 Union Blvd.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>1390 Union Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Zella</b> Middle Last <b>Helton</b>				4. DATE OF DEATH Month <b>7</b> Day <b>27</b> Year <b>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>10/20/69</b>		9. AGE (last birthday) <b>90</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
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>Home</b>		11. BIRTHPLACE (City and state or country) <b>Berry, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Aaron Decker</b>				13b. MOTHER'S MAIDEN NAME <b>Lydia Phennager</b>				14. NAME OF HUSBAND OR WIFE <b>Charles V. Helton</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>Mrs. Gladys Jenkins, 1390 Union</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>Myocardial failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>General Anasarca</b> DUE TO (c) <b>Cardio vascular renal disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>many yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>442 X</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 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 <b>Jan. 57</b> to <b>July 27-60</b> and last saw her <b>alive</b> on <b>July 20-1960</b> Death occurred at <b>6:45 P.M.</b> on the date stated above, and to the best of my knowledge from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Frank C. Batangard</b>						22b. ADDRESS <b>O.C. 5020 Page Blvd.</b>				22c. DATE SIGNED <b>July 28-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>7/30/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) <b>Hannibal</b>		STATE <b>Mo.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Herral, 1905 Union Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>JUL 28 1960</b>		26. REGISTRAR'S SIGNATURE <b>Roal Smith M.D.</b> <i>m ds</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

5020 Page  
Po 7-2308  
Hrs. Thurs. 12-5

### 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

*Warren A. Co*

Licensed Embalmer No. 353

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.