

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1960

60-032132  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8523

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u>		Length of stay in lb <u>25 Yrs.</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2330 S. 12th</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2330 S. 12th</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle Last <u>DUNCAN</u>			4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1960</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/78</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Hoodo, Tenn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Martin</u>	13b. MOTHER'S MAIDEN NAME <u>Martha East</u>	14. NAME OF HUSBAND OR WIFE <u>Jasper (Deceased)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT Address <u>Alpha Duncan, 2330 S. 12th</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Arterio sclerotic Heart Disease</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Genil Arterio scleros</u>	
DUE TO (b)	<u>420.0</u>	
DUE TO (c)		

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
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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 16.)
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20c. TIME OF INJURY Hour Month, Day, Year p.m.	
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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
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21. I attended the deceased from <u>5/3/60</u> to <u>8/29/60</u> and last saw her alive on <u>8/29/60</u> Death occurred at <u>1:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree title) <u>Carol Henderson M.D.</u>	22b. ADDRESS <u>4268 Dela</u>	22c. DATE SIGNED <u>8/30/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9/1/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetary</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>McLAUGHLIN'S, 2301 Lafayette</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 30 1960</u>	26. REGISTRAR'S SIGNATURE <u>Roald Smith, M.D.</u>
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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 James R. Chapman  
Licensed Embalmer No. 415  
P. O. Address H. Paul

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