

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis, Missouri		Length of stay in 1b 4-9-55		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Masonic Home of Missouri				d. STREET ADDRESS 2831 Magnolia		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Wyatt				4. DATE OF DEATH Month 8 Day 27 Year 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 11-2-1873	
9. AGE (last birthday) 87		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.N.		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 Henry Deno		13b. MOTHER'S MAIDEN NAME Sophie Pidgeon		14. NAME OF HUSBAND OR WIFE Wallace Wyatt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Masonic Home of Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 1 Mo.	
DUE TO (b) Generalized Arteriosclerosis						Week	
DUE TO (c) 331x							
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 5-15-60 to 8-27-60 and last saw her alive on 8-27-60 Death occurred at 6.45 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Dress or title) Harold E. Walters M.D.				22b. ADDRESS 3720 Washington St. Louis Mo.		22c. DATE SIGNED 8-28-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-31-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Rd Mo.	
24. FUNERAL DIRECTOR Herman Rindskopf Inc 5212 Delmar				25. DATE RECD. BY LOCAL REG. AUG 29 1960		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

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 Ketter

Licensed Embalmer No. 3880

P. O. Address _____

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.