

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>University City</b>	
				d. STREET ADDRESS (If outside, give location) <b>6823 Melrose</b>	
				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>	
First <b>Mary</b>	Middle <b>J.</b>	Last <b>Parrot</b>	Month <b>Oct.</b>	Day <b>1</b>
			Year <b>1960</b>	

<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10/12/73</b>	<b>9. AGE (last birthday)</b> <b>86</b>	<b>IF UNDER 1 YEAR</b> Months <b>11</b> Days <b>19</b>	<b>IF UNDER 24 HR</b> Hours      Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Switzerland</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>Francis Frossard</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Emile</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <b>Rose Carney</b>	<b>Address</b> <b>6823 Melrose</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b>
IMMEDIATE CAUSE (a) <b>myocardial thrombosis</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerosis</b>	
	DUE TO (c) <b>450.0</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>generalized arteriosclerosis</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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour      Month, Day, Year a.m.      p.m.	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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<b>21. I attended the deceased from</b> <b>10/9/54</b> to <b>death</b> and last saw her/him alive on <b>9/20/60</b> <b>1:40 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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<b>22a. SIGNATURE</b> <b>Robert Bowie M.D.</b>	<b>22b. ADDRESS</b> <b>8720 Washington St Louis</b>	<b>22c. DATE SIGNED</b> <b>10/3/60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>10/4/60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park</b>	<b>23d. LOCATION (City, town, or county)</b> <b>St. Louis County, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> <b>Chas. F. Stuart</b>	<b>ADDRESS</b> <b>1225 Union</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 3 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Loan Smith, M.D.</b>
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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 Harvey Kahl

Licensed Embalmer No. 4596

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.