

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS. NOV 28 1960 318**

Registration District No. **8** Primary Registration District No. **1003**

Registrar's No. **11258**

**-60-043581**  
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Mo</b>		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 Mo</b>		c. CITY OR TOWN <b>St Louis Mo</b>	
Length of stay in 1b <b>13 days</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>St John's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>#18 S.Kingshighway Blvd</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Harriet</b> Middle <b>Frost</b> Last <b>Fordyce</b>	4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>60</b>
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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>4-24-1876</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.	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) <b>at home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St Louis Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Daniel Frost</b>	13b. MOTHER'S MAIDEN NAME <b>Harriet Chenie</b>	14. NAME OF HUSBAND OR WIFE <b>Samuel (Deceased)</b>
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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) <b>No.</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>C.P.Fordyce 706 Olive St. Louis Mo.</b>
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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)	<b>Arteriosclerotic Heart Disease</b>	<b>3 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary Artery Sclerosis</b>	<b>3 "</b>
	DUE TO (c) <b>Generalized Arteriosclerosis</b>	<b>-</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Thrombosis 4201</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
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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 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **Nov 2, '60** to **Nov 21, '60** and last saw her **live** on **Nov 21, '60**  
Death occurred at **2:30 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Dee or title) <b>Alphonse McArthur, M.D.</b>	22b. ADDRESS <b>634 N. Grand Blvd</b>	22c. DATE SIGNED <b>11-21-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-23-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St Louis Mo</b>	(State)
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24. FUNERAL DIRECTOR <b>Arthur J. Smully</b>	ADDRESS <b>3840 Lindell Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Francis Hillier

Licensed Embalmer No. 35

P. O. Address 3840

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.