

DED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Length of stay in 1b 25 Years		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 807 Clara Ave				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 807 Clara Ave	
3. NAME OF DECEASED (Type or print) First Bertha Middle Neal Last Lawrence				4. DATE OF DEATH Month December Day 13 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/4/1881	
9. AGE (last birthday) 79		IF UNDER 1 YEAR Months		IF UNDER 24 HR Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired)				10b. KIND OF BUSINESS OR INDUSTRY 1st. National Bank		11. BIRTHPLACE (City and state or country) Hampton, New York	
12. CITIZEN OF WHAT COUNTRY U.S.A.				13a. FATHER'S NAME Albert A. Lawrence			
13b. MOTHER'S MAIDEN NAME Julia Neal				14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 497-18-9650		17. INFORMANT Mrs Marjorie A. Walker	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive heart disease				DUE TO (b)		DUE TO (c) 443x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus				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 8/6/59 to 12/13/60 and last saw her ^{her} alive on Nov 9/60 Death occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Arthur E. Strouth, M.D.				22b. ADDRESS 3798 Washington		22c. DATE SIGNED 12/14/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/15/60		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri	
24. FUNERAL DIRECTOR Alexander & Sons				25. DATE RECD. BY LOCAL REG. DEC 14 1960		26. REGISTRAR'S SIGNATURE Roald Smith, M.D.	
ADDRESS 6175 Delmar Blvd							

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 J. Allen Davis

Licensed Embalmer No. 405

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.