

FILED VS FEB 9 1961 318

Primary Registration District No. 1003

Registrar's No.

835

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				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</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3221 TEXAS AVE</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3221 TEXAS AVE</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>BEST</b> Last				4. DATE OF DEATH Month <b>JAN</b> Day <b>26</b> Year <b>1961</b>									
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>MAY 11, 1885</b>		9. AGE (last birthday) <b>75</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>					
13a. FATHER'S NAME <b>CONRAD DUEWELL</b>				13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				14. NAME OF HUSBAND OR WIFE <b>CHARLES PETER BEST</b>					
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. <b>NONE</b>		17. INFORMANT Address <b>GERTRUDE SCHAUHANN 3221 TEXAS</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic cardiovascular disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)			DUE TO (c)			<b>422.1</b>				
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 s.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 <b>11 June 1960</b> to <b>26 Jan 61</b> and last saw <sup>her</sup> <del>him</del> alive on <b>25 Jan. 1961</b> Death occurred at <b>1:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Robert S. Nye, M.D.</b>						22b. ADDRESS <b>3201 Arsenal St. St. Louis Mo.</b>			22c. DATE SIGNED <b>27 Jan. 1961</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JAN 30, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER + PAUL CEM.</b>		23d. LOCATION (City, town, or county) <b>ST. LOUIS</b>		23e. STATE <b>MO.</b>					
24. FUNERAL DIRECTOR <b>Thomas Rutis 2906 Gravois</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 27 1961</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>							

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Samuel C. Hill

Licensed Embalmer No. 4347  
P. O. Address 2906 Snow

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.