

AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

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, MISSOURI			Length of stay in 1b 6 DAYS	c. CITY OR TOWN CLAYTON		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7705 Country Club ex		
3. NAME OF DECEASED (Type or print) First DEWITT Middle Last DAWKINS			4. DATE OF DEATH Month JANUARY Day 26 Year 1961			
5. SEX MALE	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 11-13-1874	9. AGE (last birthday) 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET DAIRYMAN		10b. KIND OF BUSINESS OR INDUSTRY MILK	11. BIRTHPLACE (City and state or country) WHITEBORO TEXAS		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME JACKSON DAWKINS		13b. MOTHER'S MAIDEN NAME FRANCES BIRD		14. NAME OF HUSBAND OR WIFE Phoebe (deceased)		
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.	17. INFORMANT MADELINE DAWKINS 7705 Country Club		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) RUPTURE OF THORACIC AORTIC ANEURYSM						
DUE TO (b) ARTERIOSCLEROSIS						
DUE TO (c) 451X						
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 type="checkbox"/> No <input type="checkbox"/> Unknown						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 JULY 15, 1943 to JAN. 26, 1961 and last saw her/him alive on JAN. 26, 1961 Death occurred at 12:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>C. Demillion, M.D.</i>			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 1/27/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1/30/1961	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS MO		
24. FUNERAL DIRECTOR Stock Hart		ADDRESS 8895 BRENTWOOD BLVD		25. DATE RECD. BY LOCAL REG. JAN 28 1961	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

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

Paul W. Astler

Licensed Embalmer No. 4729

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.