

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 471 - 61-003187 STATE FILE NUMBER

AMENDED

DATE AMENDED

THIS RECORD ARE AS FOLLOWS

SHOULD READ

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 <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>4453 North Market</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Roberta</u> Middle <u>Herron</u> Last			4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>61</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-1894</u>	9. AGE (last birthday) <u>68</u>	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) <u>NIL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>MISS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>EDWARD MCFARLAND</u>		13b. MOTHER'S MAIDEN NAME <u>OLIVELY ALLEN</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>ELIZABETH H. BARNARD 4453 N. MARKET</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>
DUE TO (b) <u>Cerebral Thrombosis, (old)</u>					<u>Undet.</u>
DUE TO (c) <u>331 X</u>					
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					
Auricular Fibrillation					
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 <u>1-9-61</u> to <u>1-13-61</u> and last saw ^{her} alive on <u>1-13-61</u> Death occurred at <u>10:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Sydney P. Inaba, M.D.</u> (Degree or title)			22b. ADDRESS <u>2601 N. Whittier St.</u>		22c. DATE SIGNED <u>1-16-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>1-18-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ALTON III</u>	
24. FUNERAL DIRECTOR <u>SWAN-MEEHEE UND. CO 1619 N.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 17 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

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 Edward A. Flynn

Licensed Embalmer No. 4444

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.