

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

VS JAN 16 1961
AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 169 -61-003373
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis, Mo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Lincoln</u>	
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>Moscow Mills</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FERMIN DESLODGE HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u></u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>LOIS</u> Middle <u>JEAN</u> Last <u>STEWART LUCKETT</u>			4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1936</u>	9. AGE (last birthday) <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (City and state or country) <u>Warren Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>

13a. FATHER'S NAME <u>Pete Stewart</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Franz</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Gerald Ball, Wentzville, Mo.</u>	

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) <u>Increased Intracranial pressure</u>		
DUE TO (b) <u>Subarachnoid Hemorrhage</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>Tonsillar Herniation 330x</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	
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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.)	
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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
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21. I attended the deceased from <u>12-28-1960</u> to <u>1-2-61</u> and last saw her alive on <u>1-2-61</u> Death occurred at <u>7:30 AM 1-2-61</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Martin J. Jurek M.D.</u>	22b. ADDRESS <u>4059 Flora Pl</u>	22c. DATE SIGNED <u>1-5-61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Wright City, Mo.</u>
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24. FUNERAL DIRECTOR <u>Nieburg Funeral Home, Wright City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 6 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

ITEM NO.

FEB 1 1961

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

Elton R. Resmelius

Licensed Embalmer No.

4283

P. O. Address

St. Louis, Mo

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.