

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-003899

STATE FILE NUMBER

FILED VS JAN 16 1961  
 AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 33

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Saint Louis</b>  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Clayton</b>  |                                  | Length of stay in 1b  | c. CITY OR TOWN <b>Elmwood Park</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis County Hosp.</b>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>10020 Meeks</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Rosetta</b> Middle <b>Hannah</b> Last   |                                  |   | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>2</b> Year <b>61</b>   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-19-08</b>   | 9. AGE (last birthday)<br><b>52</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Chesterfield, Mo. U.S.A.</b>                |   |
| 13a. FATHER'S NAME<br><b>Moses Brooks</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Rosie Lee James</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Hayward Hannah</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br>Address<br><b>Hayward Hannah, 10020 Meeks</b>                               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO (b) <b>Cerebral arteriosclerosis</b><br>DUE TO (c) <b>Arteriosclerosis, generalized</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 _____, to _____ and last saw her/him alive on _____.<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.  |                                  |   |  |  |   |
| 22a. SIGNATURE<br><b>Albert L. Howe M.D.</b> (Degree or title)   |                                  |   | 22b. ADDRESS<br><b>601 S. Brentwood</b>  |  | 22c. DATE SIGNED<br><b>1/3/61</b>   |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify)<br><b>Burial</b>   |                                  | 23b. DATE<br><b>1/7/61</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chesterfield Cemetery</b>   |  | 23d. LOCATION (City, town, or county)<br><b>Chesterfield, Mo.</b>                     |
| 24. FUNERAL DIRECTOR<br><b>Charles J. Gates, 4107 Finney</b>   |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>1-5-61</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>John C. Murphy M.D.</b>                               |

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 ITEM NO.

**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 Gupton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.