

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-006818  
STATE FILE NUMBER

318

Primary Registration District No. 1003

Registrar's No. 1379

AMENDED

Registration District No. FILED VS FEB 20 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5553 Cates Ave.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sharon</b> Middle Last <b>Proudie</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>8</b> Year <b>1961</b>
5. SEX <input checked="" type="checkbox"/> <b>FEMALE</b>	6. COLOR OR RACE <b>N</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-6-1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>10</b> Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.,</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Sonia Proudie</b>	
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. <b>None</b>		17. INFORMANT Address <b>Geraldine Proudie 5533 Cates Ave.</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>Bilateral Basal Hemorrhagic Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hemorrhagic</b> DUE TO (c) <b>Bronchopneumonia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>General debility due to prematurity</b>			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.) <b>491x</b>	
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 <b>Jan 1961</b> to <b>Feb 1961</b> and last saw her live on <b>Feb 8 1961</b> Death occurred at <b>3p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree title) <b>Charles H. Dart, M.D.</b>		22b. ADDRESS <b>216 So Kingshighway</b>	
22c. DATE SIGNED <b>2/10/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-11-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b> (State)
24. FUNERAL DIRECTOR ADDRESS <b>G. Wade Granberry 4202 Finney Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 10 1961</b>	26. REGISTRAR'S SIGNATURE <b>Robert 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

*Edward A. Flynn*

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.