SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1369 STATE FILE NUMBER 61-006856

FILED VS FEB 28 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4352 W.Belle
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 4352 W.Belle
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First William Middle M. Last Rowe
4. DATE OF DEATH Month 2 Day 7 Year 61
5. SEX Male
6. COLOR OR RACE Col.
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 2-16-1891
9. AGE (last birthday) 69
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) Laborer
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (City and state or country) Lexington, Miss.
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Ester
14. NAME OF HUSBAND OR WIFE Celia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT Celia Rowe Address 4352 W. Belle Pl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Angina Pectoris — INTERVAL BETWEEN ONSET AND DEATH 3 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis
DUE TO (c) 420.1
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 4-Oct-60 to 7-Feb-61 and last saw her/him alive on 6-Feb-61
Death occurred at 10 P.M. on the date stated above, and the best of my knowledge from the causes stated.

22a. SIGNATURE M. A. Muener (Degree or title) M.D.
22b. ADDRESS 3524 Franklin Ave. St. Louis 6, Mo.
22c. DATE SIGNED FEB 10 1961

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 2-13-61
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis (State) Mo.

24. FUNERAL DIRECTOR A.L. Beal Und. Co. ADDRESS 4303 Delmar
25. DATE RECD. BY LOCAL REG. FEB 10 1961
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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

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 Arthur L Heilland

Licensed Embalmer No. 4221

P. O. Address 3100 Easton 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.