

AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>			Length of stay in 1b <u>1 Week</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6719 Dolan Pl.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle Last <u>Duff</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/02</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardware Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Central Hdwe.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>George F. Duff</u>			13b. MOTHER'S MAIDEN NAME <u>Emma Armstrong</u>			14. NAME OF HUSBAND OR WIFE <u>Osie F. Duff</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.		17. INFORMANT Address <u>Mrs. Osie Duff, 6719 Dolan Pl.</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>Uremia</u>							<u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic nephrosclerosis</u>							<u>year</u>
DUE TO (c) <u>arteriosclerosis</u>							<u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia 446x</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)					
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>Feb. 18, 1949</u> to <u>March 13, 1961</u> and last saw him ^{her} alive on <u>March 12, 1961</u> Death occurred at <u>4:30 A</u> .m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Joseph C. Edwards M.D.</u>				22b. ADDRESS <u>3720 Washington Blvd. St. Louis Mo.</u>		22c. DATE SIGNED <u>3/13/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3/15/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Upper Alton Cemetery</u>		23d. LOCATION (City, town, or county) <u>Upper Alton, Ill.</u>		
24. FUNERAL DIRECTOR <u>Drehmann-Harral 1905 Union Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>MAR 13 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

Dr. Jos. C. Edwards
3720 Washington
Fr 1-3737
Hrs. 1:30 to 5:30 PM

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 Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address _____

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.