

FILED VS MAR 13 1961 18

1003

2091

F-61-010928

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis, Mo</i> | | Length of stay in 1b | | c. CITY OR TOWN <i>ST. LOUIS</i> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Luke's Hospital</i> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <i>1221 Chambers</i> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>THOMAS DWAYNE HARGROVE</i> | | | | 4. DATE OF DEATH Month Day Year <i>FEB. 11 61</i> | | | |
| 5. SEX <i>MALE</i> | | 6. COLOR OR RACE <i>White</i> | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <i>FEB 10-61</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <i>1 5</i> | | 11. BIRTHPLACE (City and state or country) <i>St Louis, Mo</i> | |
| 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | | 13a. FATHER'S NAME <i>THOMAS LOREN HARGROVE</i> | | 13b. MOTHER'S MAIDEN NAME <i>HELEN ELEANOR KING</i> | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <i>Mother</i> | | Address <i>1221 CHAMBERS ST. ST. LOUIS 6, MO</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coarctation aorta. Patent ductus cardio-pulmonary artery central hemiplegia atherosclerosis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1' 5"</i> | |
| DUE TO (b) _____ | | | | | | | |
| DUE TO (c) <i>Presenescence</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>754.6</i> | | | | | | 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.) | | | |
| 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 <i>2-10-61</i> to <i>2-11-61</i> and last saw her/him alive on <i>2-11-61</i> Death occurred at <i>12:55 PM</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Dr. Edward Helen M.D.</i> | | | | 22b. ADDRESS <i>5535 Delmore</i> | | 22c. DATE SIGNED <i>2-21-61</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>MAR 31 1961</i> | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i> | | 23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i> | |
| 24. FUNERAL DIRECTOR ADDRESS <i>Rowland Mortuary Svc. 4104-06 Manchester</i> | | | | 25. DATE REC'D. BY LOCAL REG. <i>MAR 2 1961</i> | | 26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> | |

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 _____

Licensed Embalmer No. _____

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.**