

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

3406

-61-011031

STATE FILE NUMBER

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

FILED APR 14 1961

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 Missouri COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST, LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN Brentwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9158 Swan Circle		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MYRA Middle E. Last HURT			4. DATE OF DEATH Month APRIL Day 6 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/17/1881	9. AGE (last birthday) 79	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Cooper Co., Mo.	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Robert Boone Smith		13b. MOTHER'S MAIDEN NAME Kate Boswell		14. NAME OF HUSBAND OR WIFE William T. Hurt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Wilma Harris, 9158 Swan Circle		
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) ANTERIOR MYOCARDIAL INFARCTION					2 DAYS
DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR HEART DISEASE					20 YEARS
DUE TO (c) 420.1A					
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
PROBABLE PULMONARY TUBERCULOSIS					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ s.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 APRIL 3, 1961 to APRIL 6, 1961 and last saw her/him alive on APRIL 6, 1961 Death occurred at 2:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. O. Vermillion, M.D.</i> (Degree or title) M. D.			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 4/7/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-9-61	23c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cemetery	23d. LOCATION (City, town, or county) (State) Boonville, Mo.		
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.		ADDRESS	25. DATE RECD. BY LOCAL REG. APR 10 1961	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>	

JUN 2 2 1962

INTERNATIONAL EMBALMERS ASSOCIATION

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 Harvey Kahle

Licensed Embalmer No. ~~4590~~ 4590

P. O. Address Lawrence, Mo

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.