

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **3472**

FILED APR 24 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		c. CITY OR TOWN ST. LOUIS, MO 3219 RUTGER	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 3219 RUTGER	

3. NAME OF DECEASED (Type or print) First JOHNNY Middle BROOM Last	4. DATE OF DEATH Month MARCH Day 29 Year 1961
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5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/16/61	9. AGE (last birthday) 7 YRS.	IF UNDER 1 YEAR Months 2 Days 13	IF UNDER 24 HR Hours 13 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME EDWARD	13b. MOTHER'S MAIDEN NAME MARY MCGEE	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT ST. LOUIS CITY HOSP, #1. Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis, aerobacter	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) 340.2	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diarrhea	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
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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.)
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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 _____
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21. I attended the deceased from **3/3/61** to **3/29/61** and last saw her/him alive on **3/29/61**
 Death occurred at **9:05 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wilma Cloonan, M.D.	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 3/29/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) 4-29-61	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR Rowland Aker 4104 Manchester ADDRESS	25. DATE RECD. BY LOCAL REG. APR 12 1961	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 _____

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.