

318

1003

3512

STATE FILE NUMBER

61-015277

AMENDED

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

FILED APR 24 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		St. Louis		Life		c. CITY OR TOWN		St. Louis			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)					
Homer G. Phillips Hospital						3664 Finney Ave.					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First		Middle		Last		Month		Day		Year	
IOLA				HUNTER		April		8		1961	
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR	
Female	Col			1-12-1922		39		Months 2 Days 26		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
Housework						St. Louis Mo		USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE			
William Johnson				Nellie Roberson				-			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				17. INFORMANT				Address			
No				Lelia				Katie Miller 2518 Arlington Ave			
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>Subdural Hematoma;</u>											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b) <u>Apparently suffered in fall in the vicinity of Grand Ave</u>											
DUE TO (c) <u>Page, on or about April 5, 1961.</u>											
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.	
										904.5	
										<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input checked="" 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.)							
				See above							
20c. TIME OF INJURY		Hour		Month, Day, Year							
7		a.m.		4-5-61							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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			
A		11 Street		St. Louis, Mo							
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____											
Death occurred at _____ <u>6:00 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED		
<u>Joseph M. Zeman Deputy Coroner</u>						1300 Clark Avenue			4-12-61		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		23e. STATE			
Removal		4-13-1961		Greenwood		St. Louis Co		Mo			
24. FUNERAL DIRECTOR ADDRESS					25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE				
J. H. RANDLE & SON 3133 Bell Ave.					APR 12 1961		<u>Loed Smith, M.D.</u>				

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

Esther H. Harris

Licensed Embalmer No.

4458

P. O. Address

4181 Wash

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.