

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

4699-61-019521

STATE FILE NUMBER

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

FILED JUN 2 1961

PARTIALLY AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

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 MO</u>		Length of stay in lb		c. CITY OR TOWN <u>St Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hosp #1</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>375 Olive St</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED <u>HERSTELL</u> (Type or print) Middle <u>STUCKER</u> Last <u>TRUCKER</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>61</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
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) <u>Kansas</u>				12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME				13b. MOTHER'S M maiden NAME				14. NAME OF HUSBAND OR WIFE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>F. E. Taylor, 1300 Clark</u> Address							
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)															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Lobar Pneumonia</u>													
		DUE TO (c) <u>left upper lobe</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. <u>490x</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>Patricia E. Taylor</u> (Degree or title)						22b. ADDRESS <u>1300 Clark</u>						22c. DATE SIGNED <u>5-1-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE <u>MAY 31 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>				23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>					
24. HOSPITAL DIRECTOR <u>Rowland Aker Mortuary Service</u> ADDRESS <u>4104 Manchester Ave.</u>						25. DATE RECD. BY LOCAL REG. <u>MAY 18 1961</u>				26. REGISTRAR'S SIGNATURE <u>Loan 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 _____

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.