

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019689

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1574

DECEASED JUN 12 1961

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Affton | | Length of stay in 1b 4 yrs. | c. CITY OR TOWN Affton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 9435 Reavis Barracks Rd. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 9435 Reavis Barracks Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | | |
|---|----------------------------------|---|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Ada Middle B. Last Bilbao | | | 4. DATE OF DEATH Month June Day 4 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 12/10/1877 | 9. AGE (last birthday) 83 | 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) Hannibal, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S. |

| | | | | | |
|---|--|---|--|---|--|
| 13a. FATHER'S NAME Marshall C. Bullock | | 13b. MOTHER'S MAIDEN NAME Mary Walden | | 14. NAME OF HUSBAND OR WIFE Pedro | |
| 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 John Dugger, 9435 Reavis Barracks Rd. | |

| | | | | | |
|--|--|--|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cor. Failure Arteriosclerosis Heart disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yr | | |
|--|--|--|---|--|--|

| | | | | | |
|---|--|--|---|--|--|
| 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 | | |
|---|--|--|---|--|--|

| | | | | | |
|--|---|--|--|---|--|
| 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 3.3.59 to 6.4.61 and last saw her live on 6.4.61
Death occurred at 10:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|------------------------------------|-----------------------------------|
| 22a. SIGNATURE W. H. Jorman M.D. (Degree or title) | 22b. ADDRESS 9505 Jarvis | 22c. DATE SIGNED 6.5.61 |
|--|------------------------------------|-----------------------------------|

| | | | |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 6-6-61 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | 23d. LOCATION (City, town, or county) (State) Hannibal, Mo. |
|---|----------------------------|---|---|

| | | | |
|---|--|---|---|
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd. | | 25. DATE RECD. BY LOCAL REG. 6-5-61 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
|---|--|---|---|

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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 Stanley A. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.