

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019984
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1445

AMENDED

FILED JUN 6 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> ; COUNTY <u>St. Louis.</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights, Mo.</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Sunset Hill</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10608 East Watson Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>V.</u> Last <u>White</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1961</u>		
5. SEX <u>Female</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 <u>4/3/1884</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Crawford County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Harrison Haley</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown) Palmer</u>		14. NAME OF HUSBAND OR WIFE <u>Henry White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Nil.</u>		17. INFORMANT <u>Aubrey White, 11625 Denny Road.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO (b) <u>Arteriolar sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</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. <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 <u>12/30/60</u> to <u>5/20/61</u> and last saw her alive on <u>5/20/61</u> Death occurred at <u>1:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. F. Melick, MD</u> (Degree or title)			22b. ADDRESS <u>3720 Washington St Louis 8</u>		22c. DATE SIGNED <u>5-22-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-21-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Home Cemetery</u>		23d. LOCATION (City, town, or county) <u>Steelville, Mo.</u> (State)	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington,</u>			25. DATE RECD. BY LOCAL REG. <u>5-23-61</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 H. Dufon

Licensed Embalmer No. 4193

P. O. Address S. L.

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.