

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5232-61-022310** STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St Louis** Length of stay in 1b **3 wks**
 c. CITY OR TOWN **Creve Coeur** Inside Limits Yes No
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St Johns Hosp** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **Marine & Fee Fee** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **Melida** Middle **Besancenez** Last **Besancenez** 4. DATE OF DEATH Month **June** Day **4** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **11/24/1880** 9. AGE (last birthday) **80** 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 **Own Home** 11. BIRTHPLACE (City and state or country) **St Louis Mo** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **Hypolite Marandon** 13b. MOTHER'S MAIDEN NAME **Marie Colln** 14. NAME OF HUSBAND OR WIFE **George (dec.)**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Joseph Besancenez Creve Coeur Mo** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **cardiac failure**
 DUE TO (b) **auricular fibrillation**
 DUE TO (c) **433.1F**
 INTERVAL BETWEEN ONSET AND DEATH **months**
OK. Death certificate signed by Paul G. Smith 6/5/61

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Fractured hip 8 days ago** PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) **fell at home**

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year **5-25-61**

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **95 home** 20f. CITY, TOWN, OR LOCATION **St. Louis Co.** COUNTY **Mo.** STATE

21. I attended the deceased from **5-25-61** to **6-3-61** and last saw her alive on **6-3** Death occurred at **6-4-61** **4 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **Thos. M. Weiler** (Degree or title) **Thomas M. Weiler MD** 22b. ADDRESS **634 N. Grand** 22c. DATE SIGNED **6-5-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **6/8/1961** 23c. NAME OF CEMETERY OR CREMATORY **St Monicas** 23d. LOCATION (City, town, or county) **Creve Coeur Mo** (State)

24. FUNERAL DIRECTOR **Ortmann F Home 9222 Lackland Overland Mo** ADDRESS 25. DATE RECD. BY LOCAL REG. **JUN 5 1961** 26. REGISTRAR'S SIGNATURE **Paul Smith. M.D.**

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF **Dr. Weiler 634 N. Grand St. 3-111D**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Al O. Ottmann

Licensed Embalmer No. 3478

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.