ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5214 STATE FILE NUMBER -61-023003

FILED JUN 16 1961

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b: life	c. CITY OR TOWN St. Louis — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Incarnate Word Hospital — Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location): 3548 Victor St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Elizabeth	Mary	Outt	June	2	1961

5. SEX	6. COLOR OR RACE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
F.	W.		2-20-1877	84				

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
Housewife	----	St. Louis, Mo.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
John Clark	Bridgett Cullen	John

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	Address
No		Kathyrn Dooley	3548 Victor St.

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)	ARTERIOSCLEROTIC GANGRENE OF BOTH FEET,	1 week
DUE TO (b)	ARTERIOSCLEROSIS GENERALIZED	?
DUE TO (c)	450.1 F	

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

O.K. Paul J. Snow Deputy Coroner 6/6/61

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): INTERTROCHANTERIC FRACTURE RIGHT FEMUR

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 FROM HER WHEEL CHAIR AT HOME

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 5/30/61

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.) HOME

20f. CITY, TOWN, OR LOCATION: ST. LOUIS MO — COUNTY — STATE

21. I attended the deceased from JAN 9, 1947, to JUNE 2, 1961 and last saw her alive on JUNE 2, 1961

Death occurred at 12 15 p m 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
John T. Vandover MD	1504 So Grand	6/3/61

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	6-5-61	Calvary	St. Louis Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Arthur J. Donnelly	3840 Lindell	JUN 4 1961	Earl Smith, M.D.

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — BY AFFIDAVIT OF — MEDICAL CERTIFICATION

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. 4699

P. O. Address 3840 London Rd

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.