

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

XC 143 8759

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SL 3549

1003

586861-023248  
STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED JUN 29 1961

DATE AMENDED

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. FRANCOIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b. <b>73 DAYS</b>	c. CITY OR TOWN <b>FARMINGTON</b> Inside Limits - Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMIN HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE 2</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>THAKE</b>			4. DATE OF DEATH Month <b>6</b> Day <b>22</b> Year <b>61</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-13-91</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE WORKER (RETIRED)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SHOE</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>WILLIAM A THAKE SR</b>	13b. MOTHER'S MAIDEN NAME <b>KATHERINE PRANGER</b>	14. NAME OF HUSBAND OR WIFE <b>HATTIE THAKE</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>	16. SOCIAL SECURITY NO. <b>WWI</b>	17. INFORMANT Address <b>HATTIE THAKE RT 2 FARMINGTON, MO.</b>
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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) <b>INTRAPULMONARY HEMORRHAGE</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ADENOCARCINOMA OF APPENDIX, METASTATIC</b>	
	DUE TO (c) <b>153.0</b>	

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 type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from <b>4-10-61</b> to <b>6-22-61</b> Death occurred at <b>8:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Galen B. Cook M.D.</b>	22b. ADDRESS <b>VA HOSPITAL 915 NO. GRAND ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>6-22-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JUNE 26 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY JEFFERSON BARRACKS MO.</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR ADDRESS <b>Thomas Kutis 2906 Gravois</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 23 1961</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>
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INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1961 9 700

**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 Eleanore Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grove

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.