MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-026380
STATE FILE NUMBER

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 169

FILED JUL 17 1961

1. PLACE OF DEATH
a. COUNTY St. Charles
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles — Length of stay in 1b: 1 Day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Bridgeton — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 4232 Fee Fee Rd. — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Eva Middle H. Last Hasty
4. DATE OF DEATH Month July Day 7 Year 1961
5. SEX Female
6. COLOR OR RACE White
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 10)30)1909
9. AGE (last birthday) 51 — 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) At Home
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (City and state or country) Eddyville Illinois
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John Trammel
13b. MOTHER'S MAIDEN NAME Martha Roberts
14. NAME OF HUSBAND OR WIFE Orville D. Hasty
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
17. INFORMANT Address Orville D. Hasty 4232 Fee Fee Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular collapse + shock
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) rupture of inferior vena cava
DUE TO (c) adherence of neurofibroma tumor
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ 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.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5-24-61, to 7-7-61 and last saw her alive on 7-7-61
Death occurred at 11:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Arne E. Carlson M.D. (Degree or title)
22b. ADDRESS 3109 Brown Rd. St Louis 14 Mo
22c. DATE SIGNED Aug 7-1961

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7)10)1961
23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery
23d. LOCATION (City, town, or county) St. Ann, (State) Mo.
24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo. ADDRESS
25. DATE RECD. BY LOCAL REG. July 7-61
26. REGISTRAR'S SIGNATURE Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

JUL 18 1961

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_____ Signed Sheldon Collier

Signature of Student Embalmer

Licensed Embalmer No. 3382

P. O. Address St. Ann M

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.