SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-027851
STATE FILE NUMBER

AMENDED

Registration District No. 917 Primary Registration District No. 543 Registrar's No. 1943

FILED JUL 19 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY ST LOUIS,
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JENNINGS — Length of stay in 1b YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5325 FLETCHER — Inside Limits Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST LOUIS,
c. CITY OR TOWN JENNINGS, — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 5325 FLETCHER — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First JOSEPH Middle F. Last SAMS

4. DATE OF DEATH Month JULY Day 11, Year 1961

5. SEX MALE
6. COLOR OR RACE WHITE
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH JULY 10,
9. AGE (last birthday) 1905 56 — 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) BOTTLER
10b. KIND OF BUSINESS OR INDUSTRY BUSH BREWERY
11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JOSEPH SAMS
13b. MOTHER'S MAIDEN NAME ANN HORACK
14. NAME OF HUSBAND OR WIFE BERNICE E. SAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
17. INFORMANT BERNICE E. SAMS Address 5325 FLETCHER

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) RESPIRATORY Collapse
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Spread
DUE TO (c) Carcinoma of the Lung
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 7/1/61, to 7/11/61 and last saw her/him alive on 7/10/61
Death occurred at 4:30 AM m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lane P. Barbour D.O.
22b. ADDRESS 2335 Brown Rd
22c. DATE SIGNED 7/12/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 7/14/61
23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY
23d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY MO.

24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE
25. DATE RECD. BY LOCAL REG. 7-12-61
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

Dr. Barber
Ev 3779
3406 Fee Fee Rd
Left 1/4
White House
Children's Home

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 M W Ruter

Signature of Student Embalmer

Licensed Embalmer No. 4865

P. O. Address St Louis 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.