

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-034089

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8442

STATE FILE NUMBER

FILED SEP 18 1961

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>			Length of stay in 1b <u>9 weeks</u>		c. CITY OR TOWN <u>St Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony's Hosp</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2122^a Cushing</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPHINE A BROWN</u>		4. DATE OF DEATH Month Day Year <u>Sept 9, 1961</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> ? Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-1895</u>	9. AGE (last Birthday) <u>67</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Janitress</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenters Council</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>William Stetina</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Snidl</u>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>LaVerne O'Hanlon 2122 Cushing</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>injury coma</u> DUE TO (b) <u>Cardio Renal Syndrome</u> DUE TO (c) <u>442X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>Injury</u>			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
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
21. I attended the deceased from <u>June 1</u> to <u>6-1</u> and last saw her alive on <u>Sept 9th 1961</u> Death occurred at <u>10:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J.H. Mayne MD</u> (Degree or title)				22b. ADDRESS <u>3606 Gravois</u>		22c. DATE SIGNED <u>9-11-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Sept 12 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cem</u>		23d. LOCATION (City, town, or county) <u>St Louis Co</u>		(State) <u>Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>SEP 11 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>	

1-4 Maryland
07-2-7980

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gravo

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.