

ISSUANCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035009

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8109

**FILED SEP 21 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> . COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #</u>		d. STREET ADDRESS (If outside, give location) <u>9a North Boyle, Ave.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Sue</u> Middle <u>Ann</u> Last <u>Surratt</u>			4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1961</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/1925</u>	9. AGE (last birthday) <u>36</u>	IF UNDER 1 YEAR Months Days Hours Min.	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) <u>Cashier Walgreen Drug,</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Co.</u>	11. BIRTHPLACE (City and state or country) <u>Gleason, Tenn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Trevathan</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Isaac</u>
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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) <u>No.</u>	17. INFORMANT <u>Isaac Surratt, 9a North Boyle, Ave.</u>	Address
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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: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning, self administered in home on 8-31-61</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>See above</u> DUE TO (c) <u>Suicide</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <u>970.2</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>See above</u>
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20c. TIME OF INJURY Hour <u>?</u> a.m. <u>8-31-61</u> Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo</u>	COUNTY	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul J. Simon</u> (Degree or title) <u>Deputy Coroner</u>	22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>8/31/61</u>
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23a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-2-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	23d. LOCATION (City, town, or county) <u>Gleason, Tenn.</u>
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24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc.,</u> ADDRESS <u>4700 Washington, Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 31 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>
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ITEM NO. SHOULD READ INSTEAD OF DOCUMENT BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DATE AMENDED

**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 Elton H. Remelues

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.