

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH																							
FILED NOV 10 1961																							
Registration District No. 318			Primary Registration District No. 1003			Registrar's No. 10347			-61-038326														
STATE FILE NUMBER																							
DATE AMENDED	AMENDED	BY AFFIDAVIT OF	MEDICAL CERTIFICATION	DOCUMENT	INSTEAD OF	SHOULD READ	BY AFFIDAVIT OF	ITEM NO.															
												1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
												a. COUNTY						a. STATE Missouri b. COUNTY					
												b. CITY (If outside corporate limits, give TOWNSHIP only)				Length of stay in 1b		c. CITY OR TOWN				Inside Limits	
												OR TOWN St. Louis						St. Louis				Yes <input type="checkbox"/> No <input type="checkbox"/>	
												c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS (If outside, give location)				Reside on Farm	
												St. Louis-Little Rock Hospital, Inc.				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		4525 Lindell Blvd.				Yes <input type="checkbox"/> No <input type="checkbox"/>	
												3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			Month Day Year		
												First Middle Last						November 6 1961					
												5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR	
Female		White				5-15-1895		66		Months Days		Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY															
Unemployed - Housework				At Home		St. Louis, Mo.		U.S.A.															
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
Robert Barr Singleton				Anne Belle Bruton				Joseph A. Bosse															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address																	
No None				None		Joseph A. Bosse 4525 Lindell Blvd.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Chronic Ulcerative Colitis Idiopathic										INTERVAL BETWEEN ONSET AND DEATH													
										27 years													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b)													
										572.2													
DUE TO (c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)																							
Cirrhosis of the liver (nutritional) Ch. Pyelonephritis																							
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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		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 <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 Oct 18 1961 to Nov. 6, 1961 and last saw her alive on Nov. 6, 1961		Death occurred at 8:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.																					
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED														
Island E. Haas M.D.						1755 S. Grand Blvd.			Nov 7 1961														
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)															
Removal		Nov. 9, 1961		Sunset Burial Park		St. Louis Co. Mo.																	
24. FUNERAL DIRECTOR				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE																	
Kreigshauser Funeral Home, St. Louis, Mo.				NOV 7 1961		Island E. Haas M.D.																	

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 R. N. Storey

Licensed Embalmer No. 4007

P. O. Address _____

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.