

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

10062

-61-938727
STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____
FILED NOV 8 1961

DATE AMENDED
11/21/61
11/21/61

INSTEAD OF
Burial, S/S Peter & Paul
St. Louis, Mo.

ITEM NO. SHOULD READ
23a, c Removal - Resurrection Cemetery - St. Louis County, Mo.
23d St. Louis County, Mo.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF Fun. Dir.

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		St. Louis			c. CITY OR TOWN		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 Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
St. John's Hospital				Yes <input type="checkbox"/> No <input type="checkbox"/>	4147 Wyoming St.				Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
MARY			ANN	HUDDLESTON		Oct.		28	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		IF UNDER 24 HR
Female	White			5-15-1916		45		Months	Days	Hours
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				
Housework		At Home		Highland, Ill.		U.S.A.				
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
John Munie			Josephine Walter			Ferdinand Huddleston				
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		Ferdinand Huddleston 4147 Wyoming St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)										10 days
Liver failure										
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										1 yr
DUE TO (b) Metastatic Carcinoma										
DUE TO (c) Adenocarcinoma of the Breast										4 yrs 6 mo
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.			
							170 x <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 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		Aug 1 1961		to		Oct 28 1961		and last saw her/him alive on		Oct 28 1961
Death occurred at		3:30 P.		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		
W.B. Hedney M.D.					St. John's Hospital			10-30-61		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)		(State)	
Burial Removal		Oct. 31, 1961		Resurrection Cemetery S/S Peter & Paul Cem.			St. Louis, Mo. County, Mo.			
24. FUNERAL DIRECTOR ADDRESS					25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE			
Kriegshauser 4228 S. Kingshighway Blvd.					OCT 30 1961		Karl Smith 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. W. Stossond

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.