

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-51-038748
STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9322

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>7 days</u>		c. CITY OR TOWN <u>Steelville</u>		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>Missouri Baptist Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Hutson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10/29/1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13a. FATHER'S NAME <u>Bill Wallace</u>			13b. MOTHER'S MAIDEN NAME <u>Julia Brockey</u>			14. NAME OF HUSBAND OR WIFE <u>Ronater (dec'd)</u>				
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. <u>unknown</u>		17. INFORMANT <u>Sonte Hutson Steelville, Missouri</u> Address					
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>Cerebral thrombosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>332x</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____					DUE TO (c) _____		
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.)						
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>Oct 26</u> to <u>Oct 6</u> and last saw her/him alive on <u>Oct 6 1961</u> Death occurred at <u>7:40 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Type or print) <u>Stanley J. Ford</u>					22b. ADDRESS <u>457 N. Kingsley Ave</u>			22c. DATE SIGNED <u>10-9-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-9-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Keysville, Missouri</u>				
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 9 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>				

MEDICAL CERTIFICATION

OCT 26 1961

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 Elmer R. Federer

Licensed Embalmer No. 4077

P. O. Address St. Louis

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.