

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

11025-51-042398  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11025

AMENDED

**FILED DEC 1 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>22 Hrs.</u>	c. CITY OR TOWN <u>Overland</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>Incarname word Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1935 Dyer</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Erline</u> Middle <u>Elizabeth</u> Last <u>Fleming</u>			4. DATE OF DEATH Month <u>11-</u> Day <u>24-</u> Year <u>61</u>			
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>9-4-11</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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 <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Augusta, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Earl Pierce Calhoun</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Davis</u>		14. NAME OF HUSBAND OR WIFE <u>Beryl Lloyd Fleming</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>None</u>		17. INFORMANT <u>B. L. Fleming, 1935 Dyer</u> Address _____		

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 <u>4 days</u> <u>1 week</u>
IMMEDIATE CAUSE (a) <u>Bacterial Broncho Pneumonia</u>			
DUE TO (b) <u>myocardial damage</u>			
DUE TO (c) <u>422.2</u>			
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 11-20-1961 to 11-24-1961 and last saw her <sup>her</sup> alive on 11-24-61  
Death occurred at 10<sup>00</sup> P M on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Herman J. Kloech M.D.</u>	(Degree or title)	22b. ADDRESS <u>9616 Hubbard Rd.</u>	22c. DATE SIGNED <u>1-27-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Decatur, Illinois</u>
24. FUNERAL DIRECTOR <u>Earl Hilleman,</u>	ADDRESS <u>Overland, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 27 1961</u>	26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Emil J. Hellman

Licensed Embalmer No. 3501

P. O. Address Portland

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.