

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH									
FILED NOV 28 1961					-61-042671				
Registration District No. 318			Primary Registration District No. 1003			Registrar's No. 10751		STATE FILE NUMBER	
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	1. PLACE OF DEATH
									a. COUNTY
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
									a. STATE
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN
									Length of stay in 1b
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
									Inside Limits
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	3. NAME OF DECEASED (Type or print)
									First
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	5. SEX
									6. COLOR OR RACE
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
									10b. KIND OF BUSINESS OR INDUSTRY
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	13a. FATHER'S NAME
									13b. MOTHER'S MAIDEN NAME
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
									17. INFORMANT
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
									IMMEDIATE CAUSE (a)
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	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.
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	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"/>
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	20c. TIME OF INJURY
									Hour
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	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.)
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	21. I attended the deceased from <u>10/18/61</u> to <u>11/18/61</u> and last saw him alive on <u>11/18/61</u>
									Death occurred at: <u>5:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	22a. SIGNATURE (Degree or title)
									22b. ADDRESS
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	23a. BURIAL, CREMATION, REMOVAL (Specify)
									23b. DATE
DATE AMENDED	2	INSIDE OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ	AMENDED	24. FUNERAL DIRECTOR
									ADDRESS

FILED NOV 28 1961

-61-042671

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10751

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 30 YRS.	c. CITY OR TOWN ST LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1524 MONTGOMERY
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) NOEL First THOMAS Middle McMAHAN Last				4. DATE OF DEATH NOVEMBER 18 1961			
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1908	9. AGE (last birthday) 53	IF UNDER 1 YEAR	IF UNDER 24 HR	
Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SET UP MAN		10b. KIND OF BUSINESS OR INDUSTRY SCREW CO.		11. BIRTHPLACE (City and state or country) ASHERVILLE, MO.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME W.M. McMAHAN			13b. MOTHER'S MAIDEN NAME KATHERINE DILLARD		14. NAME OF HUSBAND OR WIFE GERTRUDE McMAHAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				17. INFORMANT Address ROSE BEAUJEAN 2209 SULLIVAN AVE.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	IMMEDIATE CAUSE (a) ACUTE HEMORRHAGIC ENTERO-COLITIS	DUE TO (b)	DUE TO (c) 571.1	INTERVAL BETWEEN ONSET AND DEATH
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 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	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>10/18/61</u> to <u>11/18/61</u> and last saw him alive on <u>11/18/61</u>		
Death occurred at: <u>5:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) J. E. Duntz M.D.	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 11/18/61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-21-61	23c. NAME OF CEMETERY OR CREMATORY ST. MATHEW CEM.
		23d. LOCATION (City, town, or county) ST. LOUIS, MO. (State)
24. FUNERAL DIRECTOR SUEDEMEYER SONS	ADDRESS 3934 N. 20TH ST.	25. DATE RECD. BY LOCAL REG. NOV 20 1961
		26. REGISTRAR'S SIGNATURE Royal Smith M.D.

DATE AMENDED

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INSIDE OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James Dinkley

Licensed Embalmer No. 3653

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.