

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046242

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12445**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		d. STREET ADDRESS (If outside, give location) 812 S. 18TH ST. REAR	

3. NAME OF DECEASED (Type or print) SADIE	4. DATE OF DEATH Month 12 Day 31 Year 61
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5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-28-91	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY 443-07-2457	11. BIRTHPLACE (City and state or country) ST. LOUIS MO	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME WILL JEFFERSON	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. —	17. INFORMANT GENEVA BRADLEY 43 CHAPMAN ST. PONTIAC, MISS	Address
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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) UREMIA		
DUE TO (b) PRELONOPHTHIS		
DUE TO (c) DIABETES MELLITUS 260		

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
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **12/25/61** to **12/31/61** and last saw her ^{her} _{him} alive on **12/31/61**
Death occurred at **9:00 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. E. Smith M.D.	(Degree or title)	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 12/31/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 1-5-62	23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON CEM.	23d. LOCATION (City, town, or county) ST. LOUIS CO. MO.
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24. FUNERAL DIRECTOR RETTIS MORTUARY 4181 WASHINGTON	ADDRESS	25. DATE RECD. BY LOCAL REG. JAN 3 1962	26. REGISTRAR'S SIGNATURE Coal Smith M.D.
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STATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 *Ethel K. Harris*

Licensed Embalmer No. 4458

P. O. Address 4181 Washington

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.