

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-046904

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11629**

STATE FILE NUMBER

AMENDED

FILED JAN 11 1962

DATE AMENDED
1/2

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b		c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital #1</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>3549 Victor</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>A.</i> Last <i>Stokes</i>				4. DATE OF DEATH Month <i>12</i> Day <i>13</i> Year <i>'61</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>7/11/1886</i>	9. AGE (last birthday) <i>75</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>John Chalcraft</i>		13b. MOTHER'S MAIDEN NAME <i>Annie Wallace</i>		14. NAME OF HUSBAND OR WIFE <i>John</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>M. A. Stokes 3549 Victor</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Fractures; suffered in fall into elevator shaft at 3115 So. Grand.</i> DUE TO (b) <i>about 6⁵⁸ - A.M., Dec. 13th, 1961.</i> DUE TO (c) <i>accident</i>							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) <i>9026-45</i>							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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>see above</i>					
20c. TIME OF INJURY Hour <i>6⁵⁸</i> p.m. Month, Day, Year <i>12-13-61</i>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>16 office bldg.</i>		20f. CITY, TOWN, OR LOCATION <i>St. Louis, Mo</i>		COUNTY	STATE	
21. I attended the deceased from <i>7:00</i> A.M. to <i>9:00</i> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Josephine Green</i> (Degree or title)				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>12-14-61</i>		
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12/16/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		23d. LOCATION (City, town, or county) <i>St. Louis Mo</i>		23e. (State)		
24. FUNERAL DIRECTOR <i>Joe A. Howard 1619 So. Grand</i>				25. DATE RECD. BY LOCAL REG. DEC 14 1961		26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>		

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 Elton R. Remel

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.