

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-047784

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12451** STATE FILE NUMBER

FILED FEB 7 1962

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		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2214th Franklin	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eliza Middle Ann Last Carroll			4. DATE OF DEATH Month 12 Day 31 Year 1961
5. SEX F	6. COLOR OF RACE C.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3.18.1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (last birthday) 77
11. BIRTHPLACE (City and state or country) La		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Ward		13b. MOTHER'S MAIDEN NAME Eva Ward	
14. NAME OF HUSBAND OR WIFE		17. INFORMANT Nineth Nelson 3951 Aldine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cerebral Hemorrhage**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **331x**

DUE TO (c)

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Joseph M. Johnson** 22b. ADDRESS **1300 Clark** 22c. DATE SIGNED **1-2-62**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **1.6.62** 23c. NAME OF CEMETERY OR CREMATORY **Oakwood Cemetery** 23d. LOCATION (City, town, or county) (State) **Alton Ill.**

24. FUNERAL DIRECTOR ADDRESS **A. H. Burkus 3901 Ashland** 25. DATE RECD. BY LOCAL REG. **JAN 3 1962** 26. REGISTRAR'S SIGNATURE **Paul Smith, M.D.**

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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

Leroy U. Jannister

Licensed Embalmer No. 4523

P. O. Address 4251 Wash

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.