

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-047817

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1368

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 b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	c. CITY OR TOWN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year		
5. SEX			6. COLOR OR RACE		
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)	
Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		Months Days		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address		Interval Between Onset and Death	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) _____

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

DUE TO (c) _____

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.
 Yes No Unknown

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 _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
22b. ADDRESS
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. NAME OF CEMETERY OR CREMATORY
23c. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR ADDRESS
25. DATE RECD. BY LOCAL REG.
26. REGISTRAR'S SIGNATURE

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

336

318

1003

1368

FILED FEB 7 1962

St. Louis 10, Mo.

Rowland-Aker Mortuary Service

Anatomical Board

St. Louis, Mo.

1300 Clark Ave.

1-17-62

Helen L. Taylor, Coroner

Charles M. Kenzie

3800 University

82

U.S.A.

U.S.A.

331X

JAN 31 1962

JAN 31 1962

Charles Smith M.D.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.