

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-047882

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3721

STATE FILE NUMBER

AMENDED

FILED JAN 19 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Louis</u>		a. STATE <u>Mo.</u>		b. COUNTY <u> </u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oakland</u>		Length of stay in 1b <u>24 days</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda Dilworth Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6157 Waterman Blv'd.</u>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <u>Maud</u> Middle <u>H</u> Last <u>Myrick</u>			Month <u>December</u> Day <u>27</u> Year <u>1961</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1871</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Buffalo N.Y.</u>	12. CITIZEN OF WHAT COUNTRY <u>US&</u>	
13a. FATHER'S NAME <u>Peter Hitte</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Etta Deming</u>		14. NAME OF HUSBAND OR WIFE <u>Frederic A. Myrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Arthur Shaw 6157 Waterman Blv'd.</u>	
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) <u>Bronchopneumonia</u>					<u>2 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>					<u>chr.</u>
DUE TO (c) <u>Arteriosclerotic vascular disease</u>					
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	
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.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u>				
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>Dec. 10 1961</u> to <u>Dec. 27 1961</u> and last saw ^{her} _{him} alive on <u>Dec 7 6 1961</u> Death occurred at <u>12 30</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>O. Deebaugh M.D.</u>			22b. ADDRESS <u>Webster Groves Mo</u>		22c. DATE SIGNED <u>12/27/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>Dec. 27, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>C.R. Lupton and Sons 7233 Delmar Blv'd.</u>			25. DATE RECD. BY LOCAL REG. <u>12-27-61</u>	26. REGISTRAR'S SIGNATURE <u>J. M. Murphy M.D.</u>	

STATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

SPECIAL MAIL DELIVERED
MAY 19 1964

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

no Embalming

Signed *Arnold W. Schoene*

Licensed Embalmer No. *3864*
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.