

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-003933

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **605**

STATE FILE NUMBER

**FILED JAN 19 1962**

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <b>St. Louis</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>Jefferson</b>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospital</b>		Length of stay in 1b <b>8</b>		c. CITY OR TOWN <b>Herculaneum</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. STREET ADDRESS <b>4200</b>		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) <b>Horn, Mary</b>				4. DATE OF DEATH Month <b>1-</b> Day <b>12-</b> Year <b>62</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-26-91</b>		
9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Pashia, Frank</b>			13b. MOTHER'S MAIDEN NAME <b>Boyer, Leona</b>			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Joseph Horn</b>			
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) <b>Myocardial Infarction</b>						<b>4 wks.</b>		
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>						<b>4 yrs.</b>		
DUE TO (c) <b>4200</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebro-Vascular Accident</b>						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 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 <b>4:25</b> a.m. <b>AM</b> Month, Day, Year <b>1-2-62</b>		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 <b>Herculaneum, Missouri</b>		
21. I attended the deceased from <b>1-2-62</b> to <b>1-11-62</b> and last saw her alive on <b>1-11-62</b> . Death occurred at <b>4:25 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Lawrence S. Kuske M.D.</b>				22b. ADDRESS <b>1325 So. Grand St. Louis Mo.</b>		22c. DATE SIGNED <b>1-12-62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>1-15-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Herculaneum Cath. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Herculaneum, Missouri</b>		
24. FUNERAL DIRECTOR <b>Vinyard Funeral Home Festus, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 15 1962</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

7001 9 2 1971 SA

1971-9-2 1971 SA

**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 *W. B. Berglund*

Licensed Embalmer No. 4976

P. O. Address Festus, 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.