

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-004229

STATE FILE NUMBER

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 795

FILED JAN 25 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>	
Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>12000 Garden Lane</b>	
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 <b>Mary</b> Middle <b>Jane</b> Last <b>Minks</b>			4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1962</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/1927</b>	9. AGE (last birthday) <b>34</b>	IF UNDER 1 YEAR Months <b>34</b> Days	IF UNDER 24 HR Hours <b>34</b> Min.
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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 <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
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13a. FATHER'S NAME <b>William Holstein</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Enders</b>	14. NAME OF HUSBAND OR WIFE <b>John Minks, Jr.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	17. INFORMANT <b>John Minks, Jr.</b>	Address <b>12000 Garden Lane</b>
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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>Metastatic fibrosarcoma of lung</b>		<b>6 mo.</b>
DUE TO (b) <b>Malignant degeneration (sarcoma) of neurofibromatosis of head.</b>		<b>20 yr.</b>
DUE TO (c) <b>1939</b>		

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
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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.)
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20c. TIME OF INJURY Hour <b>2:15</b> a.m. <b>P</b> Month, Day, Year <b>1-16-62</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>St. Louis, Mo.</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>1-3-62</b> to <b>1-16-62</b> and last saw her <b>live</b> on <b>1-16-62</b>	
Death occurred at <b>2:15 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <b>W.B. Gidney</b> (Degree or title) <i>W.B. Gidney</i>	22b. ADDRESS <b>St. John's Hosp</b> <i>St. John's Hospital</i>	22c. DATE SIGNED <b>1-17-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/19/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Morrell Mortuary</b>	ADDRESS <b>3710 North Grand</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 18 1962</b>	26. REGISTRAR'S SIGNATURE <i>Loel Smith, M.D.</i>
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DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

200: 7: 10: 10: 10: 10:

**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 Law M. Sizemore

Licensed Embalmer No. 4343

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.