

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -62-007971

DEPARTMENT OF PUBLIC HEALTH AND WELFARE 318 Primary Registration District No. 1003 Registrar's No. 1987 STATE FILE NUMBER

AMENDED
 1 2 DATE AMENDED
 1 2
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 776
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP) OR TOWN		25 yrs. Length of stay in 1b		c. CITY OR TOWN		Inside Limits									
		St. Louis		11 mo. 10 days		St. Louis		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS (If outside, give location)											
Chronic Hosp.				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		5800 Arsenal St.											
3. NAME OF DECEASED (Type or print)			First			Middle			Last								
			Mariah						Dodson								
4. DATE OF DEATH			Month			Day			Year								
			2			15			62								
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR					
Female		Col.				7-4-1865		96		Months		Days					
										Hours		Min.					
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY					
Housewife				--				Baldwin, Missouri				U. S. A.					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE									
John Shelton				Mariah ?				Jake Dodson									
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.				17. INFORMANT				Address					
No				--				John Dodson				4262a W. Garfield					
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>myocardial infarction</u>										<u>one day</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>coronary arteriosclerosis</u>				<u>three years</u>			
										DUE TO (c) <u>4201</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 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		Month, Day, Year													
		a.m.															
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>3-5-36</u> to <u>2-15-62</u> and last saw her alive on <u>2-15-62</u>																	
Death occurred at <u>12:40 a.m.</u> 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							
<u>Marvin G. Fingerood, M.D.</u>					<u>5800 Arsenal St.</u>					<u>2-15-62</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)									
Removal		2/19/62		Washington Park Cem.				St. Louis County, Mo.									
24. FUNERAL DIRECTOR					ADDRESS					25. DATE RECD. BY LOCAL REG.							
Charles J. Gates					4107 Finney Av.					FEB 19 1962							
										26. REGISTRAR'S SIGNATURE							
										<u>Neal Smith, M.D.</u>							

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 Gregory Swann
Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.