

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008128

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Filed FEB 10 1962

Primary Registration District No. _____

Registrar's No. _____

1681

1003

318

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

St. P. Causey, Jr.

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY 6 yrs. b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY c. CITY OR TOWN St. Louis d. STREET ADDRESS (If outside, give location) 4325 N. 19th St.	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie Green		4. DATE OF DEATH Month Day Year 2-6-62	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-30-74
9. AGE (last birthday) 87		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR 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) Germany
12. CITIZEN OF WHAT COUNTRY Unknown		13. NAME OF HUSBAND OR WIFE	
13a. FATHER'S NAME John Schneider		13b. MOTHER'S MAIDEN NAME Wilhelmina Snyder	
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 Chronic Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO (b) _____ DUE TO (c) 4500 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH day of death
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 a.m. p.m. Month, Day, Year	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 9-29-55 to 2-6-62 and last saw her alive on 2-6-62 Death occurred at 12:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Marvin G. Fingerhood, M.D.		22b. ADDRESS St. Louis Chronic Hospital	22c. DATE SIGNED 2-7-62
23a. BURIAL, CREMATION, REMOVAL (Specify) cremated	23b. DATE 2-10-62	23c. NAME OF CEMETERY OR CREMATORY City Crematory	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Frank O'Donnell ADDRESS 5600 Arsenal St.		25. DATE RECD. BY LOCAL REG. FEB 9 1962	26. REGISTRAR'S SIGNATURE Road 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.

NOT EMBALMED CREMATED BY CITY

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.