

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2447-62-008161
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2447**

FILED MAR 15 1962

VS 300
Rev. 4/59

1

2 **223**

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4 **1**

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11

12 **600**

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DATE AMENDED
4/2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 Days	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 2237 Oregon			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First MA YME Middle HARRINGTON Last			4. DATE OF DEATH Month FEB. Day 28 Year 1962			5. SEX Female		6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/14/05	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler			10b. KIND OF BUSINESS OR INDUSTRY Artcraft Vet. Blind Co.			11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Joseph Rettig				13b. MOTHER'S MAIDEN NAME Unknown				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)			16. SOCIAL SECURITY NO.			17. INFORMANT Address Mrs. Warren Braswell, 1637 Ludwig							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral Hemorrhage										INTERVAL BETWEEN ONSET AND DEATH 40 hours			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										331X			
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 _____ 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 2-27-62 to 2-28-62 and last saw her/him alive on 2-28-62 Death occurred at 10:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Jack M. Ester, M.D. (Deceased or title)					22b. ADDRESS 8707 Grand St. Louis, Mo.			22c. DATE SIGNED 3/2/1962					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal		23b. DATE 3/3/62		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill			23d. LOCATION (City, town, or county) St. Louis Co., Mo.						
24. FUNERAL DIRECTOR McLaughlin F.H., 2301 Lafayette ADDRESS					25. DATE RECD. BY LOCAL REG. MAR 2 1962		26. REGISTRAR'S SIGNATURE Loed Smith, M.D.						

USE BLACK INK OR TYPEWRITER RIBBON

MAR 8 1963

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 H. G. Jarvis

Licensed Embalmer No. 3384

P. O. Address St. Louis

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.