

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008419  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1715**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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24015-3

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

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		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
ST. LOUIS		ST. LOUIS, MO.		4 days		Missouri		St. Louis		Ballwin		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
ST. LOUIS CITY HOSP #1						Pine Crest Nursing Home											
3. NAME OF DECEASED (Type or print)						First		Middle		Last		4. DATE OF DEATH Month Day Year					
BERTHA						McKEE						2 8 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 Months Days		IF UNDER 24 HR Hours Min.					
Female		White				11/16/73		88 years									
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)		12. CITIZEN OF WHAT COUNTRY							
Housework				Own Home				St. Louis, Missouri		USA							
13a. FATHER'S NAME						13b. MOTHER'S MAIDEN NAME						14. NAME OF HUSBAND OR WIFE					
John Abel						Unknown						Late John F. McKee					
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						None		None Mrs. Virginia Martin, 3360 Rockingham Florissant, Mo.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <i>Ischemic gangrene of jejunum, ileum, colon, rectum.</i>																	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.																	
DUE TO (b) <i>Colic, superior &amp; inferior mesenteric art. Occlusion</i>																	
DUE TO (c) <i>Arteriosclerosis</i>																	
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							
										450-1							
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 checked="" 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					
				St. Louis				St. Louis				Missouri					
21. I attended the deceased from <u>2-5-62</u> to <u>2-8-62</u> and last saw her/him alive on <u>2-8-62</u> Death occurred at <u>6:25 pm</u> m on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (D. name or title)						22b. ADDRESS						22c. DATE SIGNED					
<i>Herbert H. Shapiro, M.D.</i>						1515 LAFAYETTE AVE						2-8-62					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)					
Burial		2/10/62		SS Peter & Paul Cemetery				St. Louis, Missouri									
24. FUNERAL DIRECTOR						ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE							
CALVIN F. FEUTZ						4828 NATURAL BRIDGE BLVD.		FEB 10 1962		<i>Head Smith, M.D.</i>							

SHAPIRO  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 Robert E. Muhlman

Licensed Embalmer No. 4916

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.