

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008437

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2361

FILED MAR 7 1962

VS 300
Rev. 4/59

1

2 217

3

4 0

5 3

6

7 0

8 1

9 X

10

11 on

12 75-3

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST. LOUIS</u>		Length of stay in lb <u>65 yrs</u>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CITY HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4131 Castleman Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALLACE MARTIN</u>		4. DATE OF DEATH Month Day Year <u>FEB. 27 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-3-1896</u>
9. AGE (last birthday) <u>65</u>		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) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Common</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>WILLIAM S. MARTIN</u>	
13b. MOTHER'S MAIDEN NAME <u>CARRIE STEIDEL</u>		14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>NO</u> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>4203 Shenandoah FLORENCE MARTIN ST. LOUIS, MO.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure with Coronary Artery Disease; Edema of the brain, trauma as a contributing factor; following injuries suffered when struck by car operated by one Glen Robinson, in the vicinity of 4100 Shaw, at Feb. 24th, 1962, about 8:45 P.M.</u> DUE TO (b) <u>accident</u> DUE TO (c) <u>accident</u>			INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>See above</u>	
20c. TIME OF INJURY Hour <u>8:45</u> a.m. / p.m. Month, Day, Year <u>2-24-62</u>		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.) <u>17 Street</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo</u> COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him live on _____ Death occurred at <u>7:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Helen L. Taylor Coroner</u>		22b. ADDRESS <u>1300 Clark Ave.</u>	
22c. DATE SIGNED <u>2-28-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>MAR. 3, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>COLLEGE HILL</u>	23d. LOCATION (City, town, or county) (State) <u>LEBANON ILL.</u>
24. FUNERAL DIRECTOR <u>MEYER FUNERAL HOME</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 28 1962</u>	26. REGISTRAR'S SIGNATURE <u>Roan 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 *Kenn Proff*

Licensed Embalmer No. 4356

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.