

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008502

318

1003

2543

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAR 15 1962

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
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12 90-0				
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90	SHOULD READ	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b	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 4944 Lindell Blvd		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4944 Lindell Blvd		
3. NAME OF DECEASED (Type or print) First Middle Last Edith Peters Mudd.			4. DATE OF DEATH Month Day Year March 5 1962		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/18/1907	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Frederick R. Peters.		13b. MOTHER'S MAIDEN NAME Helen Johnston.		14. NAME OF HUSBAND OR WIFE Robert D. Mudd.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mr. Robert D. Mudd; 4944 Lindell Blvd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes DUE TO (b) Chronic calcific pancreatitis DUE TO (c) 577.1 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					INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs.
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 1950 to Mar 5, 1962 and last saw her alive on Mar. 4, 1962 Death occurred at 7:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE George W. Stues, M.D. (Degree or title)		22b. ADDRESS 600 N. Union Blvd		22c. DATE SIGNED 3-5-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 3/6/1962	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
24. FUNERAL DIRECTOR ADDRESS C.R. Lupton & Sons; 7233 D'lar Blvd;			25. DATE RECD. BY LOCAL REG. MAR 5 1962		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

Dr. George Ittner
600 Union FO-1-1256
1:00 To 5:00 P.M.

City Visé

A.W.S.

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.