

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008538

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2669

STATE FILE NUMBER

FILED MAR 15 1962

VS 300  
Rev. 4/59  
1  
24040 3  
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4 1  
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1255-0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis, Mo		Length of stay in lb 40 Minutes	c. CITY OR TOWN Shrewsbury St Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Memorial		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7707 Sutherland
3. NAME OF DECEASED (Type or print) First Middle Last Oberkfell, Susan Marie		4. DATE OF DEATH Month Day Year 3/8/62	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/27/61
9. AGE (last birthday) 6Mo		IF UNDER 1 YEAR Months 6 Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY US		13. FATHER'S NAME Harold Oberkfell	
14. MOTHER'S MAIDEN NAME Clara (Kloppel)		15. NAME OF HUSBAND OR WIFE None	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	18. INFORMANT Harold Oberkfell, 7707 Sutherland
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Milk</u>		INTERVAL BETWEEN ONSET AND DEATH, 1-5 min	
DUE TO (b) <u>Expiratory lung disease 6 mos</u>			
DUE TO (c) <u>5272</u>			
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	
20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
23. TIME OF INJURY Hour a.m. p.m.	24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	25. CITY, TOWN, OR LOCATION COUNTY STATE	
26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		27. I attended the deceased from <u>3-6-62</u> to <u>3-8-62</u> and last saw her/him alive on <u>3-6-62</u>	
28. Death occurred at <u>7:10pm 3-8-62</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		29. SIGNATURE (Degree or title) <u>James R. Danahoe, M.D.</u>	
30. ADDRESS <u>950 Francis Place</u>		31. DATE SIGNED <u>3-8-62</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	33. DATE <u>Mar. 12, 1962</u>	34. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u>	35. LOCATION (City, town, or county) (State) <u>St. Louis, County, Missouri</u>
36. FUNERAL DIRECTOR <u>M.J. Croghan, 7825 Big Bend Blvd.</u>		37. DATE RECD. BY LOCAL REG. <u>MAR 9 1962</u>	38. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

OK  
John J. Taylor  
Coroner

**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

*Stanley H. Dixon*

Licensed Embalmer No.

*4193*

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.