

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008679
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1886

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 23 1962

VS 300
Rev. 4/59

1
2 22

3
4 0
5 0

6
7 2
8 2

9
10
11

12 7.5-1
13

DATE AMENDED

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		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		ST. LOUIS CITY HOSP # I		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN		ST. LOUIS							
d. STREET ADDRESS		218 S. 4th		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Yes <input type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year						
ERNEST			SCHLATTER			I			27 62						
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
MALE		WHITE				12/27/78		83		Months Days Hours Min.					
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			
NONE				NONE				SWITZERLAND				???			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
JAKE				MARY											
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				NO				???				ST. LOUIS CITY HOSP. #1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a)															
DUE TO (b)															
DUE TO (c)															
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 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		12-28-61		to		1-27-62		and last saw her/him alive on		1-27-62					
Death occurred at		5:30 P.M.		m		on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title)				22b. ADDRESS				22c. DATE SIGNED							
John Mc Donough M.D.				1515 LAFAYETTE AVE.				1-28-62							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)							
Kowland-Aker Mortuary Service		2-28-62		Anatomical Board				St. Louis, Mo.							
24. FUNERAL DIRECTOR'S NAME AND ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE									
484 Manchester Ave. St. Louis 10, Mo.				FEB 15 1962		Earl Smith, M.D.									

MCDONOUGH 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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.