

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009289
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 623

FILED MAR 2 1962

VS 300 Rev. 4/59

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24000

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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 <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. -If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis County 37, Mo.</u>		Length of stay in b. <u>YRS.</u>	c. CITY OR TOWN <u>St. Louis County 37</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>2231 Ashton Drive</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2231 Ashton Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Abbie</u> Middle <u>F.</u> Last <u>Mc Coy</u>			4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5/1873</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G. A. Buder</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Owen J. Mc Coy</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Mulick</u>		14. NAME OF HUSBAND OR WIFE <u>Never Married</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Helen B. Mc Coy, 2231 Ashton Drive</u>		
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) <u>Arteriosclerotic Heart Disease</u>					<u>at least 1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
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 (e) <u>Arteriosclerosis, generalized; (2) Malnutrition; (3) Dehydration</u>					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 <u>Feb. 1961</u> to <u>Feb. 19, 1962</u> and last saw her alive on <u>Feb. 19, 1962</u> Death occurred at <u>11:25 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John A. Frotte M.D.</u>			22b. ADDRESS <u>302 Northland Med. Bldg.</u>		22c. DATE SIGNED <u>2/20/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2/22/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis</u>	(State) <u>Missouri</u>
24. FUNERAL DIRECTOR <u>JOHN STYGAR & SON, 5541 RIVERVIEW BL.</u>		25. DATE RECD. BY LOCAL REG. <u>2-21-62</u>		26. REGISTRAR'S SIGNATURE <u>John B. Mulick M.D.</u>	

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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

8700 Levee Road
St. Louis, Mo. 63114

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 *J. M. Rister*

Licensed Embalmer No. 3980

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.