

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3155 = 62-012473  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED APR 6 1962**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3155**

VS 300  
Rev. 4/59

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4/13-3  
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4 1  
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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

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b 5 wks	c. CITY OR TOWN Florissant
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9 Ridgelawn Ct. Reside on Farm Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH BELL BOLTON			4. DATE OF DEATH Month Day Year March 22, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY **	9. AGE (last birthday) 84
11a. FATHER'S NAME Charles Jones		11b. BIRTHPLACE (City and state or country) Keokuck, Iowa	
13a. FATHER'S NAME Charles Jones		13b. MOTHER'S MAIDEN NAME Emma	
14. NAME OF HUSBAND OR WIFE Deceased		17. INFORMANT Address Mrs. Alverda Radie, 9 Ridgelawn Ct., Florissant, Mo.	
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.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>uremia + kidney failure post op.</i>			INTERVAL BETWEEN ONSET AND DEATH 5-7 da.
DUE TO (b) <i>Adenocarcinoma, descending colon</i>			4-5 mo.
DUE TO (c) <i>Colon resection + anastomosis.</i>			27 da.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Injury + generalized arteriosclerosis</i>			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.) 153.2	
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>2-26-62</u> to <u>3-22-62</u> and last saw her alive on <u>3-22-62</u> Death occurred at <u>9:30 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>L. J. Sawyer MD</i>		22b. ADDRESS 2739 N. Grand	22c. DATE SIGNED 3-23-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-24-1962	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR The Florissant Mortuary, Florissant, Mo.		25. DATE RECD. BY LOCAL REG. MAR 23 1962	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

**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 *Gene P. Hutchens*

Licensed Embalmer No. 4966

P. O. Address *Florisant, 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.