

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-012816

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3324**

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 6 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|--|---------------------------|---|--|
| 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, MO. | | Length of stay in 1b 21.D. | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1 | | d. STREET ADDRESS 1127 Dillon Dr. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last (BABY GIEL) Rochelle Lorraine IRVING | | 4. DATE OF DEATH Month Day Year 3 25 62 | |
| 5. SEX F | 6. COLOR OR RACE N | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-8-62 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. PLACE (City and state or country) St. Louis, Mo |
| 13a. FATHER'S NAME Marcus Holmes | | 13b. MOTHER'S MAIDEN NAME MARIE IRVING | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 1127 Dillon | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infected Meningococci | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 751K | | 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"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 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 2/8/62 to 3/25/62 and last saw her alive on 3/25/62 Death occurred at 7:00 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Lensed Duling M.D. | | 22b. ADDRESS 1515 LAFAYETTE AVE | |
| 22c. DATE SIGNED 3/25/62 | | 23. LOCATION (City, town, or county) (State) St. Louis MO | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3-29-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Father Dixon | | 23d. LOCATION (City, town, or county) (State) Kirkwood MO | |
| 24. FUNERAL DIRECTOR ADDRESS A.H. Burkes 3901 Ashland | | 25. DATE RECD. BY LOCAL REG. MAR 29 1962 | |
| 26. REGISTRAR'S SIGNATURE Louise Smith, M.D. | | | |

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,

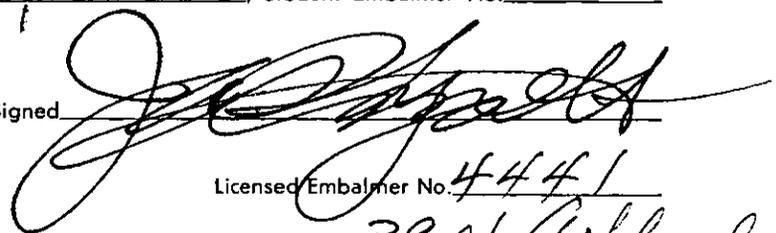
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4441

P. O. Address 3901 Goshland

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.