

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED APR 6 1962 318

-62-012948

STATE FILE NUMBER

Registration District No. 1003 Primary Registration District No. 1003 Registrar's No. 3480

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Overland
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Little Rock Hospital, Inc. MO. - PAC.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9430 Marlowe Ave
3. NAME OF DECEASED (Type or print) First Mamie Middle Mary Last McDaniels		4. DATE OF DEATH Month April Day 1 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not employed - HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (City and state or country) PHELPS COUNTY, MO.
13a. FATHER'S NAME Doc CROCKER		13b. MOTHER'S MAIDEN NAME ELIZABETH LESCHER	14. NAME OF HUSBAND OR WIFE Thomas McDaniels
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wpr or dates of service) NO NONE		16. SOCIAL SECURITY NO. NONE	17. INFORMANT THOMAS Mc DANIELS - 9430 MARLOWE AV
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 1 MO.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE		years	
DUE TO (c) 4200			
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Feb. 26, 1962 to April 1, 1962 and last saw her alive on MAR. 31 1962		Death occurred at 1:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Harrison M.D. (Degree or title)		22b. ADDRESS 1755 S. Grand Blvd	22c. DATE SIGNED 4-2-62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL-AUTO	23b. DATE 4-4-1962	23c. NAME OF CEMETERY OR CREMATORY CITY CEMETERY	23d. LOCATION (City, town, or county) (State) BONNE TERRE, MISSOURI
24. FUNERAL DIRECTOR Baumann Bros, Inc. Overland . Mo.		25. DATE RECD. BY LOCAL REG. APR 2 1962	REGISTRAR'S SIGNATURE Loan Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

EMBALMER

STATE OF MISSOURI

DEPARTMENT OF HEALTH

PLATE NO.

MISSOURI STATE BOARD OF HEALTH

DATE

TIME

PLACE

BY

NAME

08

1881-11-9

X

NAME

ADDRESS

LOCATION

THIS IS TO CERTIFY

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 Jay M. Sizemore

Licensed Embalmer No. 4343

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.