

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012965

3376

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3376**

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

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4966 Sutherland Ave.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4966 Sutherland Ave.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GENEVIEVE Middle MAPES Last						4. DATE OF DEATH Month March Day 30th Year 1962							
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-24-75		9. AGE (last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY never employed		11. BIRTHPLACE (City and state or country) Cleveland Ohio		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME James M. Mapes				13b. MOTHER'S MAIDEN NAME Louella Morton				14. NAME OF HUSBAND OR WIFE -----					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Joseph Power 4966 Sutherland Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure - Myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Seizure DUE TO (c) 422.2										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) as above stated								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 --- Month, Day, Year --- s.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 mch 19th/62 mch 30/62 and last saw her alive on mch 30/62 Death occurred at 1:00AM m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Frank L. Davis M.D. (Degree or title)						22b. ADDRESS 6123 Westview Pl.			22c. DATE SIGNED 3/24/62 (State)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail)			23b. DATE 3-30-62		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) COLDWATER MICHIGAN					
24. FUNERAL DIRECTOR KRIEGSHAUSER 4228 S. Kingshighway ADDRESS						25. DATE REG. BY LOCAL REG. MAR 30 1962		26. REGISTRAR'S SIGNATURE Loard 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 R. W. Stovessand

Licensed Embalmer No. 4007

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.