

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-013201

3026

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED MAR 26 1962

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

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		Length of stay in lb 7 yrs. 2 mo.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3225 N. Florissant Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alice Middle Last Smith			4. DATE OF DEATH Month 3 Day 15 Year 62
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 8-31-76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	9. AGE (last birthday) 85 IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR
11a. FATHER'S NAME John Gillespie		11b. MOTHER'S MAIDEN NAME Anna Cavanaugh	11. BIRTHPLACE (City and state or country) Mo.
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		12b. SOCIAL SECURITY NO. None	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John Gillespie		13b. MOTHER'S MAIDEN NAME Anna Cavanaugh	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		14b. SOCIAL SECURITY NO. None	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis		16. NAME OF HUSBAND OR WIFE Eugene Smith	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 600-0A		17. INFORMANT Angelia Stuevie Address St. Vincent DePaul 4140 Lindell	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary tuberculosis		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 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 1-4-55 to 3-15-62 and last saw her/him alive on 3-15-62 Death occurred at 10:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE J. E. Smith (Degree or title)	
22b. ADDRESS		22c. DATE SIGNED 3/19/62 (State) Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/20, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis
24. FUNERAL DIRECTOR Cullen & Kelly 7267 Natural Bridge		25. DATE RECD. BY LOCAL REG. MAR 20 1962	26. REGISTRAR'S SIGNATURE Loan 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

James A. Lemmer

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.