

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013670

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1117

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 16 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 <u>ST LOUIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST LOUIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PINE LAWN</u> | | Length of stay in 1b <u>YRS</u> | c. CITY OR TOWN <u>PINE LAWN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SHAMROCK NURSING HOME</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3709 MANOLA AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE A SEWELL</u> | | | 4. DATE OF DEATH Month Day Year <u>APRIL 7 1962</u> |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB 6 1868</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MILLER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) <u>93</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 11a. FATHER'S NAME <u>GEORGE SEWELL</u> | | 11b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | 12. CITIZEN OF WHAT COUNTRY <u>MISSOURI U-S-A</u> |
| 13a. FATHER'S NAME | | 14. NAME OF HUSBAND OR WIFE <u>MARY JANE SEWELL</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT Address <u>EDWIN SEWELL 6813 LANSDOWNE</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1) AS dementia 2) blind</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 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>Jan 14, 1956</u> to <u>April 7, 1962</u> and last saw him alive on <u>Apr 6, 1962</u> Death occurred at <u>830 A</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE - <u>Lewis Lettmann M.D.</u> (Degree or title) | | 22b. ADDRESS <u>8231 Clayton Rd (17)</u> | 22c. DATE SIGNED <u>4/9/62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>APR 10 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kuts 2906 Gravois</u> | | 25. DATE RECD. BY LOCAL REG. <u>4-9-62</u> | 26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u> |

EMBALMER

Dr Louis Hartman
8231 Cleveland Rd
Pa 7-8202
3-5

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 *Leahy Thompson*

Licensed Embalmer No. *4869*

P. O. Address *Bellevue 3, 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.