

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

3777-62-016609

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **FILED APR 25 1962**

Primary Registration District No.

Registrar's No.

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b Life	6. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.		b. COUNTY	c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
b. COUNTY		St. Louis			Mo.			St. Louis		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
St. John's Hospital					6756 Devonshire Ave.					
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
Mary			A.		Brandt	April 9th., 1962				
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR		
F.	W.		11/18/1876	85		Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
Housewife					St. Louis, Missouri		U.S.			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
Edward Burke			Sarah Carr			Mr. John William Brandt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no					Mr. Edward H. Brandt,		1117 Jennings Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)										4 weeks
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)										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
Acute Gastroenteritis										
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.)					
					332x					
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		
		Nov 1954		4-9-62				4-8-62		
21. I attended the deceased from _____ to _____ and last saw her _____ live on _____										
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Print or type)			22b. ADDRESS			22c. DATE SIGNED				
William O. Gurnea MD			4401 Hampton			4-9-62				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		23e. STATE		
Burial		4/12/1962		Calvary Cemetery		St. Louis, Missouri				
24. FUNERAL DIRECTOR					ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
Arthur J. Donnelly					3840 Lindell Blvd.		APR 10 1962		Road Smith, M.D.	

Also Bill A. Dennis 1918 to 4 PM
4401 Hampton Terrace

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 Wm S. Dallen

Licensed Embalmer No. 4699

P. O. Address 3840 1/2th St

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.