

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016912

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

3982

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

1  
2 213  
3  
4 1  
5 2  
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7 0  
8 2  
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12 90-0  
13

DATE AMENDED  
INSTEAD OF  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
SHOULD READ  
ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <del>St. Louis</del>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <del>ST. LOUIS</del>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b <u>4 YRS</u>	c. CITY OR TOWN <u>ST LOUIS</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>RES. 5944 SCANLAN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5944 SCANLAN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMELIA SCHAEFER JABIN</u>			4. DATE OF DEATH Month Day Year <u>April 14 1962</u>
5. SEX <u>FEMALE</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>9/10/67</u>
9. AGE (last birthday) <u>94</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST CHARLES Co, MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>HENRY SCHTOER</u>	
13b. MOTHER'S MAIDEN NAME <u>HENRIETTA SCHNARR</u>		14. NAME OF HUSBAND OR WIFE <u>August Jabin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address <u>Miss BERTHA JABIN 5944 Scanlan</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>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Aortic Stenosis</u>			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.) <u>334X</u>	
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 <u>Dec. 1959</u> to <u>4/14/62</u> and last saw her/him alive on <u>4/13/62</u> Death occurred at <u>3:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Richard J. James MD</u>		22b. ADDRESS <u>9313 Manchester</u>	22c. DATE SIGNED <u>4/14/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4/17/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WRIGHT CITY CEM.</u>	23d. LOCATION (City, town, or county) <u>WRIGHT CITY, MO</u>
24. FUNERAL DIRECTOR <u>KEMPER-MARSH FUNERAL HOME TROY, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>APR 17 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

Ad.



**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 Joseph J. Marsh Sr.

Licensed Embalmer No. 3932

P. O. Address TROY, 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.