

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017221

3868

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3868

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 25 1962

VS 300
Rev. 4/59

1

2 22

3

4 1

5 2

6

7 0

8 2

9

10

11

12 63-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
		<u>ST. LOUIS</u>				<u>MO.</u>				<u>ST. LOUIS</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>						<u>3120 TEXAS AVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
		<u>INCARNATE WORD HOSP</u>											
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH Month Day Year			
				<u>LILLIAN</u>				<u>SASS</u>		<u>APRIL 12 1962</u>			
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 Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
<u>FEMALE</u>		<u>WHITE</u>				<u>FEB. 14 1885</u>		<u>77</u>					
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			
<u>HOUSE WORK</u>				<u>AT HOME</u>				<u>MISSOURI</u>		<u>U-S-A</u>			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE					
<u>WILLIAM JACKSON</u>				<u>UNKNOWN</u>				<u>HERMAN SASS</u>					
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					
<u>NO</u>				<u>NONE</u>		<u>LILLIAN HILL</u>		<u>3120 TEXAS AVE</u>					
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)												<u>12 hrs</u>	
DUE TO (b)												<u>10d</u>	
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	
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.				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>4/2/62</u> to <u>4/12/62</u> and last saw her <u>live on 4/12/62</u> Death occurred at <u>10:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>R. Nachmeyer M.D.</u>						22b. ADDRESS <u>4065 S. Grand</u>			22c. DATE SIGNED <u>4/13/62</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)			
<u>REMOVAL</u>		<u>APR. 14 1962</u>		<u>PARK LAWN CEMETERY</u>			<u>ST. LOUIS CO.</u>			<u>MO.</u>			
24. FUNERAL DIRECTOR <u>Thomas Kutia 2906 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>APR 14 1962</u>		26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>							

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 Eleanore

Licensed Embalmer No. 3403

P. O. Address 2906 Javori

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.

Dr. Hachemeyer 4065 S. Grand
FL 3-4434 130-4 Fri