

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-020129

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5099

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 31 1962

<b>1. PLACE OF DEATH</b> a. COUNTY  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u> Length of stay in 1b  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSPITAL</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY  c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>903 HICKORY ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

<b>3. NAME OF DECEASED</b> (Type or print) First <u>LULU</u> Middle <u>AMAD</u> Last  <b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>MAR 15 1897</u> <b>9. AGE (last birthday)</b> <u>65</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.			<b>4. DATE OF DEATH</b> <u>MAY 18 1962</u> Month Day Year		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>AT HOME</u> <b>11. BIRTHPLACE</b> (City and state or country) <u>MISSOURI</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>U-S-A</u>		<b>13a. FATHER'S NAME</b> <u>SIMON KHOURY</u> <b>13b. MOTHER'S MAIDEN NAME</b> <u>SARAH MALLOUF</u> <b>14. NAME OF HUSBAND OR WIFE</b> <u>TONY AMAD</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>NONE</u> <b>17. INFORMANT</b> <u>TONY AMAD 4700 VIENNA</u> Address					

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Ovarian Carcinoma</u> DUE TO (c) <u>175.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>  <u>6 mo.</u>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------

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	
-----------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
-------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------	--

<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------

<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
-------------------------------------------------------------------------------------------------	--------------------------------------------------

21. I attended the deceased from March 1, 62 to 5/18/62 and last saw her alive on 5/18/62  
 Death occurred at 5/18/62 1230P on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>John J. Henselly M.D.</u>	<b>22b. ADDRESS</b> <u>6500 Chippewa</u>	<b>22c. DATE SIGNED</b> <u>5/19/62</u>
-------------------------------------------------------------------------	---------------------------------------------	-------------------------------------------

<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>REMOVAL</u>	<b>23b. DATE</b> <u>MAY 21 1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>RESURRECTION CEM.</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>
--------------------------------------------------------------------	----------------------------------------	-----------------------------------------------------------------------	----------------------------------------------------------------------------------

<b>24. FUNERAL DIRECTOR</b> <u>Thomas Huth 2906 Gravois</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>MAY 21 1962</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Road Smith. M.D.</u>
----------------------------------------------------------------	-----------------------------------------------------------	-------------------------------------------------------------

VS 300 Rev. 4/59

1

2 22

3

4 1

5 1

6

7 0

8 1

9

10

11

12 74-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

74

*W. J. Jones*  
*Reg 451*

*Dr. John Mernally*

**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 *Corey Thompson Jr.*

Licensed Embalmer No. *486*

P. O. Address *Stuyvesant Ave.*

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.