

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020802

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5505**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5505**
FILED JUN 7 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 5 Days	c. CITY OR TOWN Sullivan
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Childrens Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 235 Elmont
3. NAME OF DECEASED (Type or print) First Joyce Middle Ann Last Nichols		4. DATE OF DEATH Month May Day 31 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-23-50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) 11 1/2 yrs.
13a. FATHER'S NAME Wilford Jr. Nichols		13b. MOTHER'S MAIDEN NAME Ann Armistead	12. CITIZEN OF WHAT COUNTRY U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mary Foust, St. Louis, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Respiratory Failure DUE TO (b) Postoperative Astrocytoma DUE TO (c) Also Fibromyolysis 193.0		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 checked="" type="checkbox"/> NO <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 5-26-62 to 5-31-62 and last saw her alive on 5-31-62 Death occurred at 7:25 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
SIGNATURE (Degree or title) Malcolm Farber MD		22b. ADDRESS 500 S. Kingshighway St. Louis, Missouri	22c. DATE SIGNED 5-31-62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 6-3-1962	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN BAR. CH. CEM.	23d. LOCATION (City, town, or county) (State) LESLIE R. R. 1, MO.
24. FUNERAL DIRECTOR H.M. EATON SULLIVAN, MO		25. DATE RECD. BY LOCAL REG. JUN 1 1962	26. REGISTRAR'S SIGNATURE Coard Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF *Coard Smith*

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 Junison N. Eaton

Licensed Embalmer No. 5066

P. O. Address Sullivan, 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.