

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020883
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5093**

FILED MAY 31 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 9 days	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Greene		c. CITY OR TOWN Roodhouse		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural Route			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BUELAH Middle NAOMI Last RAWLINS			4. DATE OF DEATH Month MAY Day 17 Year 1962						
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1905	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) East of Roodhouse, Illinois.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Denton Brickley			13b. MOTHER'S MAIDEN NAME Olevia Anderson			14. NAME OF HUSBAND OR WIFE Eugene Rawlins			
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. Nil		17. INFORMANT Eugene Rawlins, Roodhouse, Illinois.		Address		
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) POST-OPERATIVE MITRAL VALVE REPLACEMENT									1 DAY
DUE TO (b) MITRAL STENOSIS AND INSUFFICIENCY									10 YEARS
DUE TO (c) RHEUMATIC FEVER 410X									MANY YEARS
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 checked="" type="checkbox"/> NO <input 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. Month, Day, Year 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 MAY 8, 1946 to MAY 17, 1962 and last saw her/him alive on MAY 17, 1962 Death occurred at 5:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>C. P. Vemellia, M.D.</i> (Degree or title)				22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 5/18/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/19/62		23c. NAME OF CEMETERY OR CREMATORY Fernwood Cemetery			23d. LOCATION (City, town, or county) Roodhouse, Illinois.		
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., ADDRESS 4700 Washington Blvd.,				25. DATE RECD. BY LOCAL REG. MAY 19 1962		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 SHOULD READ

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 USE BLACK INK OR TYPEWRITER RIBBON

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

Hary Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.