

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

51482-020892

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

FILED MAY 31 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hospital		c. CITY OR TOWN Pevely	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.R.1	
3. NAME OF DECEASED (Type or print) First Middle Last Thelma J. Reissing		4. DATE OF DEATH Month Day Year May 20, 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 5/30/1933
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) Perryville, Mo.
13a. FATHER'S NAME Emmett Taylor		13b. MOTHER'S MAIDEN NAME Mamie Felty	14. NAME OF HUSBAND OR WIFE Lloyd Reissing
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Lloyd Reissing, Pevely, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent carcinoma of colon with generalized metastases DUE TO (b) Primary carcinoma of Rt. Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 153.0			INTERVAL BETWEEN ONSET AND DEATH 6 mos. 1 yr.
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. p.m. Month, Day, Year		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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.)	
21. I attended the deceased from June 1961 to May 20, 1962 and last saw her alive on May 20 - '62 Death occurred at 10:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George A. O'Sullivan, M.D.		22b. ADDRESS 7629 Ivory Ave.	22c. DATE SIGNED 5-21-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-21-62	23c. NAME OF CEMETERY OR CREMATORY Good Shepard Cemetery	23d. LOCATION (City, town, or county) (State) Hillsboro, Mo.
24. FUNERAL DIRECTOR Heiligtag Funeral Home, Antonia, Mo.		25. DATE RECD. BY LOCAL REG. MAY 21 1962	26. REGISTRAR'S SIGNATURE Keon Smith, M.D.

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 Robert M. Murray

Licensed Embalmer No. 3749

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.