

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-021071

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5328**

**FILED JUN 7 1962**

DO NOT WRITE ON THIS STUB

AMENDED

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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

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>St. Louis</b>		c. CITY OR TOWN <b>AFFTON</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. ANTHONY HOSPITAL</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>11033 PATSY DR</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>THEOBALD</b> Last <b>THEOBALD</b>						4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>1962</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 25 1962</b>		9. AGE (last birthday) IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO</b>	
13a. FATHER'S NAME <b>LE ROY THEOBALD</b>				13b. MOTHER'S MAIDEN NAME <b>MARY ANN HEA</b>				14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>LE ROY THEOBALD</b>		Address <b>11033 PATSY DR</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatal Infection</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Prematurity</b>											
DUE TO (c) <b>773.5</b>											
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 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.		Month, Day, Year									
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>5/25</u> to <u>5/25</u> and last saw him alive on <u>5/25</u> Death occurred at <u>3:10</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <b>Robert A. Brennan M.D.</b>						22b. ADDRESS <b>3674 South Dunl</b>			22c. DATE SIGNED <b>5-26-62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>MAY 28 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS CO. MO.</b>					
24. FUNERAL DIRECTOR <b>Thomas Hutia 2906 Gravois</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 28 1962</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>					

*Dr Robert Brown*

~~3006~~ *Gravis*

*PR 6-2205*

*A. Howard was under  
PM 218*

**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.

*Not Embalmed*

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Robert*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address *2906 Gravis*

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.