

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022461

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 100 Primary Registration District No. _____ Registrar's No. 55

FILED JUN 21 1962

VS 300
Rev. 4/59

10330

22039

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Dent</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>--</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springcreek Twp.</u> Length of stay in lb <u>18 hours</u> | | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.R. 4, Salem, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>3241 Childress</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle _____ Last <u>ENGEL</u> | | | 4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1962</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/15/06</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver (Ret)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>City Government</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> |
| 13a. FATHER'S NAME <u>Justus Engel</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Lorraine</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW II</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT <u>3241 Childress Loraine Engel St. Louis, Mo.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis (41x-942.7)</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</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 type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input 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 _____ | | | |
| 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>--</u> to <u>--</u> and last saw ^{XX} him alive on <u>--</u> . Death occurred at <u>4:00 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Alicia S. Crosby M.D.</u> | | 22b. ADDRESS <u>Salem, Missouri</u> | 22c. DATE SIGNED <u>6/12/62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>6/12/1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u> |
| 25. DATE RECD. BY LOCAL REG. <u>6/12/62</u> | | 26. REGISTRAR'S SIGNATURE <u>M.M. Hart M.D. J. Am</u> | |

USE BLACK INK OR TYPEWRITER RIBBON

JUN 21 1962

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 Max L. Crawford

Licensed Embalmer No. 4170

P. O. Address Salem, Missouri

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.