

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

5995-62-024621

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED JUL 2 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

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		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY			
St. Louis		St. Louis				Mo.		Jefferson			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
Deaconess Hospital						Route 1					
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
Enoch M. Foster									Month Day Year 6 15 62		
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR IF UNDER 24 HR	
Male		White				5/15/85		77		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
Millwright - Ret.				U.S. Defense		Rock Creek, Ill.		U.S.A.			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE			
Clem Ferrell				Mary Alice Foster				Grace Foster			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No						Mrs. Grace Foster		Hillsboro, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) ENCEPHALOMALACIA OF LEFT BRAIN SECONDARY TO CEREBRAL DUE TO (b) THROMBOSIS										4 mos.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE										5 yrs.	
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.			
DIABETES MELLITUS. 332X								<input type="checkbox"/> Yes <input 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. 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 JUNE 11, 1957 to JUNE 15, 1962 and last saw him alive on JUNE 15, 1962 Death occurred at 1:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE						22b. ADDRESS			22c. DATE SIGNED		
Robert E. Coch, M.D.						35. N. CENTRAL			6-16-62.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)			
removal		6/18/62		Memorial Park Cem.		St. Louis County		Mo.			
24. FUNERAL DIRECTOR				ADDRESS				25. DATE RECD. BY LOCAL REG.		REGISTRAR'S SIGNATURE	
Drehmann-Harral				1905 Union				JUN 18 1962		Robert Smith, M.D.	

Dr. Robert Koch
35 N. Central

Hrs. 11:30 - 3 PM Sat.

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 Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address _____

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.