

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025280

STATE FILE NUMBER

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

6078

318 1003

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 2 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY		c. CITY OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1818 N. 9th St.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)						First Martha Middle Isabelle Last Tweedy			4. DATE OF DEATH Month 6 Day 17 Year 1962				
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-6-1879		9. AGE (last birthday) 82		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR 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				11. BIRTHPLACE (City and state or country) Alto Pass, Ill.		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Herman Morgan				13b. MOTHER'S MAIDEN NAME Rebecca Smith				14. NAME OF HUSBAND OR WIFE Unknown					
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. No		17. INFORMANT Dorothy Cook Address 1818 N. 9th St.							
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) Retroperitoneal Hemorrhage													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Heparin Toxication. DUE TO (c) 434.1													
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. _____ 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 6/9/62 to 6/17/62 and last saw her/him alive on 6/17/62 Death occurred at 10:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.						22a. SIGNATURE <i>John Mc Donough M.D.</i> (Degree or title)		22b. ADDRESS 1515 Lafayette Ave.		22c. DATE SIGNED 6/17/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-20-1962		23c. NAME OF CEMETERY OR CREMATORY Jonesboro, City, Cem.		23d. LOCATION (City, town, or county) Jonesboro, Union, Ill.							
24. FUNERAL DIRECTOR Norris & Son ADDRESS Jonesboro, Ill.				25. DATE RECD. BY LOCAL REG. JUN 19 1962		26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i>							

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

Amended; #2 given for Prob. Thrombosis due to Congestive Heart Failure

MEDICAL CERTIFICATION

MCDONOUGH
USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

1

2 *226*

3

4 *1*

5 *2*

6

7 *1*

8 *1*

9

10

11

12 *75-0*

13

75

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 *James T. Creason*

Licensed Embalmer No. 5168

P. O. Address *Millstadt Ill*

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.