

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-026244

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 173

FILED JUL 25 1962

DO NOT WRITE ON THIS STUD

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY CALLAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton, Missouri		Length of stay in 1b 16½ months		c. CITY OR TOWN City of St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1413 Olive St.	
3. NAME OF DECEASED (Type or print) GLENNIE CUTTING		First Middle Last		4. DATE OF DEATH Month July Day 14 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> 7 Divorced <input type="checkbox"/>	8. DATE OF BIRTH ? 1898	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (City and state or country) Michigan	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Unk.		13b. MOTHER'S MAIDEN NAME Unk.	
14. NAME OF HUSBAND OR WIFE Unk.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk			
16. SOCIAL SECURITY NO. Unk		17. INFORMANT Records received from St. Louis State Hospital by Fulton State Hospital.			
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) Myocardial Infarction					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b)					
DUE TO (c)					
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. X attended the deceased from State Hospital No. 1 Feb. 27, 1962 to July 14, 1962 and last saw her alive on July 14, 1962 Death occurred at 7:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Heidi P. ...</i>		(Degree or title)		22b. ADDRESS State Hospital No. 1	
22c. DATE SIGNED July 14, 1962					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-17-62	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) Columbia	
24. FUNERAL DIRECTOR Robert D. Johnston		ADDRESS Columbia Mo.		25. DATE RECD. BY LOCAL REG. July 14-1962	26. REGISTRAR'S SIGNATURE <i>Maretha Lawrence</i>

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 _____

Licensed Embalmer No. _____

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.