

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028279

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 205

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

<p style="font-size: 18pt; font-weight: bold; color: red;">FILED AUG 8 1962</p> <p>1. PLACE OF DEATH a. COUNTY <u>St. Charles</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> Length of stay in 1b <u> </u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u></p> <p>c. CITY OR TOWN <u>St. Charles</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>1604 Wilmes</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED First Middle Last <u>John F. Deters</u></p>			<p>4. DATE OF DEATH Month Day Year <u>July 30, 1962</u></p>			
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>		
<p>8. DATE OF BIRTH <u>10-20-1910</u></p>		<p>9. AGE (last birthday) <u>51</u></p>		<p>IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.</p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u></p>			<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>Bowling Green, Mo.</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>			<p>13a. FATHER'S NAME <u>George Deters</u></p>			
<p>13b. MOTHER'S MAIDEN NAME <u>Elizabeth Purk</u></p>			<p>14. NAME OF HUSBAND OR WIFE <u>Alvena Kohlhepp Deters</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no Yes World War II</u></p>			<p>16. SOCIAL SECURITY NO. <u> </u></p>		<p>17. INFORMANT Address <u>6 Mrs. Alvena Deters, St. Charles, Mo.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Carcinoma of tongue, i</u></p> <p style="text-align: center;">DUE TO (b) <u>metastasis</u></p> <p style="text-align: center;">DUE TO (c) <u> </u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>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</p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>one year</u></p>						
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>		
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		
<p>20f. CITY, TOWN, OR LOCATION</p>		<p>COUNTY</p>		<p>STATE</p>		
<p>21. I attended the deceased from <u>1953</u> to <u>Present</u> and last saw her/him alive on <u>7/30/62</u></p> <p>Death occurred at <u>7/30/62</u> <u>400</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>						
<p>22a. SIGNATURE (Degree or title) <u>Dr. C. Baue, M.D.</u></p>			<p>22b. ADDRESS <u>304 So. 2nd, St. Charles, Mo.</u></p>		<p>22c. DATE SIGNED <u>8/1/62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>8-2-1962</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u></p>		
<p>23d. LOCATION (City, town, or county) <u>St. Charles, Mo.</u></p>		<p>24. FUNERAL DIRECTOR ADDRESS <u>Arthur C. Baue, St. Charles, Mo.</u></p>				
<p>25. DATE RECD. BY LOCAL REG. <u>8-1-62</u></p>			<p>26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u></p>			

VS 300 Rev. 4/59

DATE AMENDED

8/20/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

No DOCUMENT

SHOULD READ

15 Yes, World War II BY AFFIDAVIT OF Informant

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1 0928
2 0928
3
4 0
5 1
6
7 0
8 1
9 91419
10
11
12 1-0
13 4-0

AUG 9 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 David C. Rowe

Licensed Embalmer No. 5060

P. O. Address St. Charles, Mo.

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.