

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-028388

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7341 STATE FILE NUMBER

**FILED AUG 6 1962**

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY                             |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MISSOURI</b>             |  | c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Enroute City Hospital</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>408 N. Euclid Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |  |

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>SERENA ALEXANDER</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JULY 25, 1962</b>    |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-6-1883</b>                           | 9. AGE (last birthday)<br><b>79</b>                      | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Manager-Lorraine Hotel-408 N. Euclid</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Coffeen, Ill.</b>   | 11. BIRTHPLACE (City and state or country)<br><b>U.S.A.</b>   |  | 12. CITIZEN OF WHAT COUNTRY               |
| 13a. FATHER'S NAME<br><b>Marcefonuf Lewis</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Ellen Green</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Late Rob Alexander</b> |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No None</b>                 |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT Address<br><b>Emma Erickson 4234a Beck Ave.</b> |  |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CONGESTIVE HEART FAILURE** INTERVAL BETWEEN ONSET AND DEATH **3 MONTHS**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **ARTERIOSCLEROTIC HEART DISEASE** **3 YEARS**

DUE TO (c) **4200**

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.  
 Yes  No  Unknown

|  |   |  |              |
|--|---|--|--------------|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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<br>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 **APRIL 6, 1962** to **JULY 23, 1962** and last saw her alive on **JULY 23, 1962**  
Death occurred at **8:00 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|   |  |                                    |
|---|--|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>F. R. BRADLEY, M. D.</b> | 22b. ADDRESS<br><b>BARNES HOSPITAL</b> | 22c. DATE SIGNED<br><b>7/26/62</b> |
|---|--|------------------------------------|

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>July 28, 1962</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Valhalla Cemetery</b> | 23d. LOCATION (City, town, or county)<br><b>St. Louis Co. Mo.</b> |
|---|-----------------------------------|--|---|

|  |  |   |
|--|--|---|
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Kriegshauser 4228 S. Kingshighway Blvd.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JUL 26 1962</b> | 26. REGISTRAR'S SIGNATURE<br><b>Roald Smith, M.D.</b> |
|--|--|---|

VS 300 Rev. 4/59  
 1  
 2 *2/29*  
 3  
 4 *1*  
 5 *2*  
 6  
 7 *1*  
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 12 *91-5*  
 13  
 91  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 USE BLACK INK OR TYPEWRITER RIBBON

**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 *R. W. Storvick*

Licensed Embalmer No. 4007

P. O. Address St. Louis 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.