

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028447

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7495 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 6 1962**

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

BRITTINGHAM USE BLACK INK OR TYPEWRITER RIBBON

|  |                  |   |       |  |        |   |      |  |                  |   |  |   |  |        |  |       |  |
|--|------------------|---|-------|--|--------|---|------|--|------------------|---|--|---|--|--------|--|-------|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN  |       | Length of stay in 1b   |        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE |      | b. COUNTY  |                  | c. CITY OR TOWN   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |        |  |       |  |
| ST. LOUIS, MO  |                  | ST. LOUIS, MO   |       |  |        | MO.   |      |  |                  | St. Louis   |  | Yes <input type="checkbox"/> No <input type="checkbox"/>                  |  |        |  |       |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION   |                  |   |       | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                              |        | d. STREET ADDRESS (If outside, give location)   |      |  |                  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |   |  |        |  |       |  |
| ST. LOUIS CITY HOSP. #1.   |                  |   |       |  |        | 1549 a S. Jefferson   |      |  |                  | Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |   |  |        |  |       |  |
| 3. NAME OF DECEASED (Type or print)  |                  |   | First |  | Middle |   | Last |  | 4. DATE OF DEATH |   |  | Month Day Year  |  |        |  |       |  |
| GRACE  |                  |   | S.    |  | BISHOP |   |      |  |                  | JULY 29, 1962   |  |   |  |        |  |       |  |
| 5. SEX   | 6. COLOR OR RACE | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |       | 8. DATE OF BIRTH   |        | 9. AGE (last birthday)  |      | IF UNDER 1 YEAR  |                  | IF UNDER 24 HR  |  |   |  |        |  |       |  |
| F  | W                |   |       | 8/26/89  |        | 72  |      | 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   |  |        |  |       |  |
| Housework  |                  |   |       | Home   |        |   |      | St. Louis Mo.  |                  |   |  | U.S.  |  |        |  |       |  |
| 13a. FATHER'S NAME   |                  |   |       | 13b. MOTHER'S MAIDEN NAME  |        |   |      | 14. NAME OF HUSBAND OR WIFE  |                  |   |  |   |  |        |  |       |  |
| Albert R. Bishop   |                  |   |       | Henrietta Langewisch   |        |   |      | None   |                  |   |  |   |  |        |  |       |  |
| 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. Anna Huskey 4012 Laclede  |                  |   |  |   |  |        |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |                  |   |       |  |        |   |      |  |                  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |        |  |       |  |
| IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON</u>  |                  |   |       |  |        |   |      |  |                  |   |  |   |  |        |  |       |  |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |        |  |       |  |
| 19. WAS AUTOPSY PERFORMED?<br>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  |                  | Hour a.m. p.m.  |       | 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 <u>7/28/62 10:45 p</u> to <u>7/29/62</u> and last saw her/him alive on <u>7/29/62</u><br>Death occurred at <u>11 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |                  |   |       |  |        |   |      |  |                  |   |  |   |  |        |  |       |  |
| 22a. SIGNATURE (Degree or title)   |                  |   |       |  |        | 22b. ADDRESS  |      |  |                  |   |  | 22c. DATE SIGNED  |  |        |  |       |  |
| <u>J. E. Dwyer M.D.</u>  |                  |   |       |  |        | 1515 LAFAYETTE AVE  |      |  |                  |   |  | 7/30/62   |  |        |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                  | 23b. DATE   |       | 23c. NAME OF CEMETERY OR CREMATORY   |        |   |      | 23d. LOCATION (City, town, or county) (State)  |                  |   |  |   |  |        |  |       |  |
| Removal  |                  | 8/2/62  |       | Bethany Cemetery   |        |   |      | St. Louis Co. Mo.  |                  |   |  |   |  |        |  |       |  |
| 24. FUNERAL DIRECTOR ADDRESS   |                  |   |       |  |        | 25. DATE REC'D. BY LOCAL REG.   |      | 26. REGISTRAR'S SIGNATURE  |                  |   |  |   |  |        |  |       |  |
| Robert D. Kinealy 2228 St. Louis Ave.  |                  |   |       |  |        | JUL 31 1962   |      | <u>Roan Smith, M.D.</u>  |                  |   |  |   |  |        |  |       |  |

CA

**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 Hubert J. Gair Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 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.