

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-028581
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7239**

FILED JUL 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 days	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Lafayette		c. CITY OR TOWN Lexington	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 239 So. 5th, St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Helen Middle N. Last Dodson				4. DATE OF DEATH Month July Day 18 Year 1962		9. AGE (last birthday) 52		IF UNDER 1 YEAR Months Days Hours Min.
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/25/1909	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietician		10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (City and state or country) Cuba, Missouri.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Will Frederickson		13b. MOTHER'S MAIDEN NAME Josephine Metlock		14. NAME OF HUSBAND OR WIFE Clinton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.			17. INFORMANT Clinton Dodson, 239 S. 5th, St.		Address			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular failure DUE TO (b) Due to athero myocardial DUE TO (c) infarct 420.				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 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 7/18/62 to 7/18/62 and last saw her alive on 7/17/62 Death occurred at 2:55 am on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) A. A. Catanzaro M.D.				22b. ADDRESS 2705 Clifton Square		22c. DATE SIGNED 7/19/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7-23-62	23c. NAME OF CEMETERY OR CREMATORY Lexington Memory Garden		23d. LOCATION (City, town, or county) (State) Lexington, Mo.			
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 1700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. JUL 23 1962		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		

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 Robert M. Murray

Licensed Embalmer No. 3749

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.