

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-028784

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7340**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 6 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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Grantwood Village	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Desloge Hospital		d. STREET ADDRESS (If outside, give location) #44 Grantwood Lane	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last HUMMEL		4. DATE OF DEATH Month July Day 24 Year 1962	
5. SEX Male	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 4-18-1903
9. AGE (last birthday) 59		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Planting Mill Operator-Park Manufacturing Co.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Hungary
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME William Hummel	
13b. MOTHER'S MAIDEN NAME Theresa Blumenschein		14. NAME OF HUSBAND OR WIFE Ann R. Hummel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Ann R. Hummel #44 Grantwood Lane		Address	
18. CAUSE OF DEATH (Enter only one cause per line for terminal disease) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer to brain			INTERVAL BETWEEN ONSET AND DEATH 4 mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cancer of lung			5 mos.
DUE TO (c) 163x			
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 checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 March to July 1962 and last saw him alive on 7/23/62 Death occurred at 7/24/62 7:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert J. Karoh, M.D. for Lester Ziffen, M.D.		22b. ADDRESS 2427 Woodson, St. Louis, Mo.	22c. DATE SIGNED 7/25/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 27, 1962	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. JUL 26 1962	26. REGISTRAR'S SIGNATURE Leon Smith, M.D.

Dr. ROBERT KARSH
2428 WOODSON Rd
OVERLAND MEDICAL CENTER

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 William B White

Licensed Embalmer No. 4241

P. O. Address 4228th Kings Highway

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.