

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-028917

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. _____ Registrar's No. **6902**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 31 1962

VS 300
Rev. 4/59

1

2 *205*

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12 *53-0*

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DATE AMENDED *11/28/62*

INSTEAD OF *9/17/1875*

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ *9/17/1885*

DOCUMENT *Baptismal Record*

MEDICAL CERTIFICATION

AFFIDAVIT OF Informant

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 50-yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5632 Maple Ave.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minnie Middle V. Last McFadden 1885						4. DATE OF DEATH Month July Day 13th. Year 1962							
5. SEX F.		6. COLOR OR RACE W.		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/17/1875		9. AGE (last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY U.S.			
13a. FATHER'S NAME Edwin Bouton				13b. MOTHER'S MAIDEN NAME Sarah McKinzie				14. NAME OF HUSBAND OR WIFE Mr. James McFadden					
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.		17. INFORMANT Address Mrs. Carry Prewitt, 601 E. Armour Blvd., Kansas City, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Urinary Bladder										INTERVAL BETWEEN ONSET AND DEATH 6 yrs 181.0			
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. <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"/>		20. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year 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 1957 to 1962 and last saw her/him alive on 12 July 62 Death occurred at 2:30 am. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Colby Byrne MD (Degree or title)						22b. ADDRESS 4660 Maryland			22c. DATE SIGNED 13 July 62				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)					
Burial		7/16/1962		Calvary Cemetery				St. Louis, Missouri					
24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.						25. DATE RECD. BY LOCAL REG. JUL 13 1962		26. REGISTRAR'S SIGNATURE Roan Smith, M.D.					

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Francis Williamson, Licensed Embalmer, No. 3565, P. O. Address 3840 Linden, Detroit, Michigan 48202.

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 Francis Williamson

Licensed Embalmer No. 3565

P. O. Address 3840 Linden

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.