

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-029224
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7129

FILED JUL 31 1962

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4025 Holly Hills</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4025 Holly Hills</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>K</u> Last <u>TAYLOR</u>						4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1962</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/15/1871</u>		9. AGE (last birthday) <u>90</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>Conrad P Bobb</u>				13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hoerner</u>				14. NAME OF HUSBAND OR WIFE <u>John L</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Emma Bobb 4025 Holly Hills</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Chronic brain syndrome</u>										<u>3 1/2 yr.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral arteriosclerosis</u>											
DUE TO (c) <u>Generalized arteriosclerotic cardiovascular disease</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</u>								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.		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 <u>3-28-51</u> to <u>7-19-62</u> and last saw ^{her} _{him} alive on <u>7-14-62</u> Death occurred at <u>10:25 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>E. E. Mueller</u> (Degree or title) <u>M.D.</u>						22b. ADDRESS <u>634 N. Grand Blvd.</u>			22c. DATE SIGNED <u>7-20-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>entombment</u>		23b. DATE <u>7/23/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Mausoleum</u>				23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>			
24. FUNERAL DIRECTOR <u>John L Ziegenhein & Sons 7027 Gravois</u> ADDRESS						25. DATE RECD. BY LOCAL REG. <u>JUL 20 1962</u>		26. REGISTRAR'S SIGNATURE <u>Neal Smith M.D.</u>			

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 Donald E. Benz

Licensed Embalmer No. 4863

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.