

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029413

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2129

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

14007  
24007

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Webster Groves, Missouri</b>		c. CITY OR TOWN <b>Webster Groves</b>	
Length of stay in 1b <b>114 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT a hospital, give location) <b>Glenwood Home &amp; Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Glenwood Home</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRIETT.</b> Middle <b>B</b> Last <b>Dudley</b>			4. DATE OF DEATH Month <b>7</b> Day <b>20</b> Year <b>62</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1874</b>
9. AGE (last birthday) <b>87</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Indiana</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Sevenil Lee</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Ann Denton</b>		14. NAME OF HUSBAND OR WIFE <b>Late Dr. Carl Dudley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Irene L. Dulin 1426 Boatmens Bank Bldg.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary embolism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>
DUE TO (b) <b>arteriosclerotic heart disease</b>			
DUE TO (c) <b>generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>cerebral arteriosclerosis</b>			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 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 <b>3-28-61</b> to <b>7-20-62</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>7-20-62</b>		Death occurred at <b>11:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Beter H. Lee (M.D.)</i>	(Degree or title)	22b. ADDRESS <b>1300 Frank Rd St. Louis 19</b>	22c. DATE SIGNED <b>7-20-62</b>
23b. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal(Mtr)</b>	23b. DATE <b>July 20, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Terre Haute, Indiana</b>
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>7-20-62</b>	26. REGISTRAR'S SIGNATURE <i>John Murphy M.D.</i>

USE BLACK INK OR TYPEWRITER RIBBON

**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 R. W. Loveland

Licensed Embalmer No. 4007

P. O. Address \_\_\_\_\_

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.