

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029460

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2070

DO NOT WRITE ON THIS STUB

AMENDED

FILED Jul 31 1962

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>County - St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koe H, Mo.</u> Length of stay in 1b <u>37 days</u>		c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robt Koeh Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>8231 Mielly</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>POLLIE</u> Middle <u>-</u> Last <u>HATTON</u>			4. DATE OF DEATH Month <u>7</u> Day <u>13</u> Year <u>1962</u>
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>W</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>9-3-78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (last birthday) <u>83</u>
13a. FATHER'S NAME <u>John Atkinson</u>		13b. MOTHER'S MAIDEN NAME <u>-.?-?</u>	14. NAME OF HUSBAND OR WIFE <u>HATTON (Deceased)</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 <u>Records - Koeh Hosp</u> Address <u>-</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Cystitis &amp; Pyelo-nephritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo?</u>
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) <u>SEVERE Decubitus Ulcer; Generalized As; ASHD</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"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>
20c. TIME OF INJURY Hour _____ 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>6-5-62</u> to <u>7-13-62</u> and last saw her alive on <u>7-13-62</u> Death occurred at <u>11:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Harold Ruess, MD</u> (Degree or title)		22b. ADDRESS <u>Koeh Hosp, Koeh Mo</u>	
22c. DATE SIGNED <u>7/14/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-14-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>Mound City ILLinois</u>
24. FUNERAL DIRECTOR <u>ALSTAT</u> ADDRESS <u>Mound City Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>7-14-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u>

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 Frank Prokop

Licensed Embalmer No. 4356

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.