

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032775

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8295

FILED AUG 31 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY _____</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u> Length of stay in 1b _____</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3625 Watson Rd.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY _____</p> <p>c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>3625 Watson Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian D. Paulette</u></p>	<p>4. DATE OF DEATH Month Day Year <u>Aug. 24, 1962</u></p>
<p>5. SEX <u>female</u></p> <p>6. COLOR OR RACE <u>white</u></p> <p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>Sept. 17, 1892</u></p> <p>9. AGE (last birthday) <u>69</u></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u></p> <p>11. BIRTHPLACE (City and state country) <u>St. Louis, Mo. USA</u></p> <p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	<p>13a. FATHER'S NAME <u>Jacob Ritter</u></p> <p>13b. MOTHER'S MAIDEN NAME <u>Unk Marcrander</u></p> <p>14. NAME OF HUSBAND OR WIFE <u>Maurice Paulette</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u></p> <p>16. SOCIAL SECURITY NO. <u>none</u></p> <p>17. INFORMANT <u>St. Louis, Mo. Maurice Paulette 3625 Watson Rd.</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Carcinoma of breast.</u></p> <p style="text-align: center;">DUE TO (b) _____</p> <p style="text-align: center;">DUE TO (c) _____ <u>170x</u></p> <p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p style="text-align: center;">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</p> <p style="text-align: right; font-size: 18pt;">INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u></p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p> <p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year _____</p> <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p> <p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p> <p>21. I attended the deceased from <u>1961</u> to <u>Aug 24, 1962</u> and last saw her/him alive on <u>Aug 24, 1962</u>. Death occurred at <u>915 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p> <p>22a. SIGNATURE <u>John G. Matthew M.D.</u> (Degree or title)</p> <p>22b. ADDRESS <u>3707 Watson Rd</u></p> <p>22c. DATE SIGNED <u>8-25-62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u></p> <p>23b. DATE <u>8-27-62</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cem.</u></p> <p>23d. LOCATION (City, town, or county) (State) <u>Lemay, Mo.</u></p> <p>24. FUNERAL DIRECTOR - ADDRESS <u>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</u></p> <p>25. DATE RECD. BY LOCAL REG. <u>8-27-1962</u></p> <p>26. REGISTRAR'S SIGNATURE <u>Paul Amstutz, M.D.</u></p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 Samuel C. Hill

Licensed Embalmer No. 4347

P. O. Address 6322 De Grand

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.