

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-032987

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7819**

FILED AUG 22 1962

VS 300
Rev. 4/59

1
2 **223**
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4 **1**
5 **2**
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7 **2**
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12 **75-0**
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DATE AMENDED

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		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Length of stay in 1b		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 type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1730 SO. 13th ST.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNETTE First Middle Last VALLENTINE						4. DATE OF DEATH AUG. 9, 1962		Month Day Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH DEC 27 1879		9. AGE (last birthday) 82		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) HOUSE WORK				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) IRELAND		12. CITIZEN OF WHAT COUNTRY U-S-A			
13a. FATHER'S NAME UNKNOWN				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE EDWARD VALLENTINE			
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. NONE		17. INFORMANT Address PHYLLIS FLEISCHMANN 2837 SO. 13th ST.					
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) Perforation Sigmoid Diverticulum											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b) Generalized Peritonitis											
DUE TO (c) Generalized Arteriosclerosis.											
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. 450.0 <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 8/6/62 to 8/9/62 and last saw her/him alive on 8/9/62											
Death occurred at 8:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE A. Schenck M.D. (Degree or title)						22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 8/9/62 (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE AUG 11 1962		23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK		23d. LOCATION (City, town, or county) ST. LOUIS CO., MO					
24. GENERAL DIRECTOR ADDRESS Thomas Kutis 1906 Gravois				25. DATE RECD. BY LOCAL REG. AUG 10 1962		26. REGISTRAR'S SIGNATURE Paul Smith M.D.					

SCHEME
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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Groves

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.