

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-52-033120
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2346

FILED AUG 20 1962

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Rev. 4/59

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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 St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN Town & Country Length of stay in lb 4 Yrs.		c. CITY OR TOWN Town & Country Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION #11 Ballas Ct. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) #11 Ballas Ct. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET R. DECKER			4. DATE OF DEATH Month Aug. Day 13 Year 1962
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 9-1-1903
9. AGE (last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (City and state or country) Scotland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Ross		13b. MOTHER'S MAIDEN NAME Grace Lunsden	
14. NAME OF HUSBAND OR WIFE Late Alfred G. Decker		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 Alfred G. Decker #11 Ballas Ct. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, involving distal stomach			INTERVAL BETWEEN ONSET AND DEATH 13 months
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) 1) Diabetes mellitus 2) Hypertensive cardiovascular disease			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 Dec 14, 1958 to Aug 13, 1962 and last saw her alive on Aug 13, 1962 Death occurred at 12:05 A. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James B. Jones M.D. (Degree or title)		22b. ADDRESS 9312 Manchester Road St. Louis 19, Mo.	22c. DATE SIGNED Aug 13, 1962 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Air)	23b. DATE Aug. 13, 1962	23c. NAME OF CEMETERY OR CREMATORY Ferncliff Cemetery	23d. LOCATION (City, town, or county) Ardaley, New York
24. FUNERAL DIRECTOR Kriegshausner 9450 Olive St. Road ADDRESS		25. DATE RECD. BY LOCAL REG. 8-13-62	26. REGISTRAR'S SIGNATURE Hub. Murphy M.D.

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. Storrsand

Licensed Embalmer No. 4007

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.