

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035929

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9594

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED OCT 11 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|  |  |   |  |  |  |  |  |   |  |   |   |                                 |                                |   |  |   |  |   |   |
|--|--|---|--|--|--|--|--|---|--|---|---|---------------------------------|--------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                     |  | Length of stay in 1b<br><b>50 Yrs.</b>   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY |  | c. CITY OR TOWN <b>St. Louis</b>                 |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |   |                                 |                                |   |  |   |  |   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Incarinate Word</b>  |  |   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         | d. STREET ADDRESS (If outside, give location)<br><b>3427 Dunnica</b>   |  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |   |   |                                 |                                |   |  |   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MARY JANE BLAYDES</b>   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Oct 5, 1962</b> |  | 5. SEX <b>Female</b>   |  |  |   |  | 6. COLOR OR RACE <b>White</b>   | 7. Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>2/14/93</b> | 9. AGE last birthday <b>69</b> |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> | 11. BIRTHPLACE (City and state or country)<br><b>Missouri</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
| 13a. FATHER'S NAME<br><b>Thomas Freeman</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Sarah Deeton</b>         |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Winfield</b> |  |   |  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                         |                                 |                                | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>       |  | 17. INFORMANT<br><b>Bernard Blaydes, 1265 Bluefield</b> |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b>  |  |   |  |  |  |  |  |   |  | DUE TO (b) <b>Endometrial Carcinoma</b>   |   | DUE TO (c) <b>172x</b>          |                                | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mo</b> |  |   |  |   |   |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |                                 |                                |   |  |   |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour 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 <u>9-11-62</u> to <u>10-5-62</u> and last saw her <u>alive</u> on <u>10-5-62</u><br>Death occurred at <u>9:50 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |  |  |  |   |  |   |   |                                 |                                |   |  |   |  |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Audrey G. K. Kern, M.D.</b>   |  |   |  |  | 22b. ADDRESS<br><b>4632 So Grand Blvd</b>  |  |  | 22c. DATE SIGNED<br><b>10-5-62</b>  |  |   |   |                                 |                                |   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>10-8-62</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Hope</b>  |  | 23d. LOCATION (City, town, or county)<br><b>St. Louis Co., Mo.</b>   |  | (State)  |   |  |   |   |                                 |                                |   |  |   |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>McLaughlin, 2301 Lafayette</b>  |  |   |  |  | 25. DATE RECD. BY LOCAL REG.<br><b>OCT 8 1962</b>  |  | REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b> |   |  |   |   |                                 |                                |   |  |   |  |   |   |

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DR. KLEIN.  
- 4632 S. GRAND



**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 *James R. Chapman*

Licensed Embalmer No. 4550

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.