

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. FILED OCT 1 1 1962 a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL		d. STREET ADDRESS (If outside, give location) 3400 S. GRAND	
3. NAME OF DECEASED (Type or print) First META Middle HAHN Last		4. DATE OF DEATH Month SEPT Day 19 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH FEB 1 1880
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) MISSOURI
12. CITIZEN OF WHAT COUNTRY U-S-A		13. NAME OF HUSBAND OR WIFE CHARLES HAHN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT CHARLES HAHN 3400 S. GRAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of left hip; Arterio Sclerosis; DUE TO Suffered in fall at home on September 16, 1962. DUE TO 904.0-2,		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) see above	
20c. TIME OF INJURY? Hour ? a.m. ? p.m. 9-16-62		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION St. Louis, MO	
21. I attended the deceased from 10:45 A to 10:45 A and last saw her/him alive on 9-16-62 Death occurred at 10:45 A on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 9-20-62	
22a. SIGNATURE (Degree or title) Joseph M. Dwyer, Jr. Deputy		22b. ADDRESS 1300 Clark	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE SEPT 21 1962	
23c. NAME OF CEMETERY OR CREMATORY ST. PETER + PAUL CEM		23d. LOCATION (City, town, or county) ST. LOUIS	
24. FUNERAL DIRECTOR Thomas Kutia 1906 Gravois		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

Covered (City)

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 *Barley H. Hopson*

Licensed Embalmer No. 4856
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.