

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036221

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9088**

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 28 1962

VS 300
Rev. 4/59

1	
2	21
3	
4	0
5	1
6	
7	0
8	2
9	
10	
11	
12	75-0
13	

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 (If outside, give location) 3836 Arsenal St.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First CLARENCE Middle R. Last HANNA			4. DATE OF DEATH Month 9 Day 20 Year 62			5. SEX Male		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 10-14-1884		9. AGE (last birthday) 77		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Worker (Retired)						10b. KIND OF BUSINESS OR INDUSTRY Mallinckrodt Chem. Co.			11. BIRTHPLACE (City and state or country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME Robert Hanna						13b. MOTHER'S MAIDEN NAME Jenny Woodworth						14. NAME OF HUSBAND OR WIFE Emma L. Hanna							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No None						17. INFORMANT Address Emma L. Hanna 3836 Arsenal St.													
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTERIOSCLEROSIS												INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4500 DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC PYELONEPHRITIS										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 5 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 8-20-62 to 9-20-62 and last saw her alive on 9-20-62 Death occurred at 5 am on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) J. E. Smith M.D.						22b. ADDRESS 1515 LAFAYETTE AVE.						22c. DATE SIGNED 9-20-62							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Sep. 22-1962		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				23d. LOCATION (City, town, or county) (State) St. Louis, Mo.										
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.						25. DATE RECD. BY LOCAL REG. SEP 20 1962		26. REGISTRAR'S SIGNATURE Roald Smith M.D.											

BRITTINGHAM

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

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 Ernest W. Spillers

Licensed Embalmer No. 4080

P. O. Address _____

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.