

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036515

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9629**

STATE FILE NUMBER

FILED OCT 11 1962

VS 300 Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

1. PLACE PAGE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Carter	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN Ellsinore	
Length of stay in lb 1 1/2 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home of Missouri		d. STREET ADDRESS (If outside, give location) Ellsinore Hotel	
3. NAME OF DECEASED (Type or print) First Gustavus Middle August Last Mone		4. DATE OF DEATH Month October Day 5 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/9/1875
9. AGE (last birthday) 87		IF UNDER 1 YEAR Months 1 Days 26	IF UNDER 24 HR Hours 26 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick and Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Evansville, Indiana
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME Gabriel Mone	
13b. MOTHER'S MAIDEN NAME Madeline Repetti		14. NAME OF HUSBAND OR WIFE Effie McWilliams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Masonic Home Of Missouri 5351 Belmar Blvd. Carl N. Stein		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) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis			unknown
DUE TO (c) 332X			
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. <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 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 April 4, 1961 to October 5, 1962 and last saw ^{her} him alive on October 5, 1962 Death occurred at 11:50 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harold E. Walters M.D.		22b. ADDRESS 3720 Washington St. Wm 10-6-62	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-9-62	23c. NAME OF CEMETERY OR CREMATORY VanBuren, Mo.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 1700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. OCT 8 1962	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

NOV 15 1962

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 John Binkley

Licensed Embalmer No. 3653

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.