

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9552

-62-036562

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. \_\_\_\_\_

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

<b>FILED OCT 11 1962</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St. Louis, Mo</b>		a. STATE <b>Missouri</b> COUNTY <b>Marion</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo</b>		c. CITY OR TOWN <b>Hannibal</b>	
Length of stay in lb <b>50 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If not in hospital give location) HOSPITAL OR INSTITUTION <b>St. Louis Children's Hospital</b>		d. STREET ADDRESS <b>420 Oak Street</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Wesley Pabst</b>			4. DATE OF DEATH Month Day Year <b>10-5-62</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-8-57</b>
9. AGE (last birthday) <b>4 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>Hannibal, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U S A.</b>		13a. FATHER'S NAME <b>Glenn E. Pabst</b>	
13b. MOTHER'S MAIDEN NAME <b>Dorothy Still</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>E. Worthington</b>		Address <b>500 S. King highway</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b>			<b>24 HR</b>
DUE TO (b) <b>RENAL FAILURE</b>			<b>1 month</b>
DUE TO (c) <b>CHRONIC Pyelonephritis</b>			<b>2.5 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>6:00-0</b>			PART III. If deceased was female was there a pregnancy in last 90 days.
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 <b>8-16-62</b> to <b>10-5-62</b> and last saw her/him alive on <b>10-5-62</b>			
Death occurred at <b>9:05 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Francis M. Henderson MD</b>		22b. ADDRESS <b>St. Louis Children's Hosp.</b>	22c. DATE SIGNED <b>5 Oct 62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-5-62</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) <b>Hannibal, Mo.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington,</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>OCT 5 1962</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

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

*Stanley H. Aiken*

Licensed Embalmer No.

*4193*

P. O. Address

*St. Louis*

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.