

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036590

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9229**

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 28 1962

VS 300  
Rev. 4/59

1  
2 *2/19*  
3  
4 *1*  
5 *2*  
6  
7 *0*  
8 *1*  
9  
10  
11  
12 *75-0*  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>			Length of stay in lb <b>Life</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. #1</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2715 N. Spring</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Hilda</b> Middle Last <b>Flover</b>			4. DATE OF DEATH Month <b>9</b> Day <b>23</b> Year <b>62</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/28/95</b>	9. AGE (last birthday) <b>67</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Henry Fiebig</b>			13b. MOTHER'S MAIDEN NAME <b>Elvina Meyers</b>			14. NAME OF HUSBAND OR WIFE <b>Edward (Deceased)</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>Unknown</b>		17. INFORMANT Address <b>Viola Anderson, 2715 N, Spring</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial meningitis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cont. of cholecystectomy + hiatus hernia repair</b> DUE TO (c) <b>Right lower lobe lung abscess</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>584x</b>					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 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>8-14-62</b> to <b>9-23-62</b> and last saw her alive on <b>9-23-62</b> Death occurred at <b>4:00 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Joseph J. Babica, M.D.</i>				22b. ADDRESS <b>1515 Lafayette Ave.</b>		22c. DATE SIGNED <b>9-23-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/26/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		(State)
24. FUNERAL DIRECTOR <b>McLaughlin, 2301 Lafayette,</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 25 1962</b>		26. REGISTRAR'S SIGNATURE <i>Roald Smith, M.D.</i>	

Joseph J. Babica, M.D.  
USE BLACK INK OR TYPEWRITER RIBBON

*Roald Smith, M.D.*

**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 J. Y. Farris

Licensed Embalmer No. 3384

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.