

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036810

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No. **1003**

1003

Registrar's No. **9246**

9246

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

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Registrar's No. **9246**

FILED SEP 28 1962

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 Years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</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>6334a Lucille</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>6334a Lucille Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>M.</b> Last <b>USHER</b>			4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>1962</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>5/14/1881</b>		9. AGE (last birthday) <b>81</b>		IF UNDER 1 YEAR Months Days 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>at Home</b>		11. BIRTHPLACE (City and state or country) <b>Greencastle, Ind.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>James Shoptaugh</b>				13b. MOTHER'S MAIDEN NAME <b>Margaret McIntyre</b>				14. NAME OF HUSBAND OR WIFE <b>John M. Usher</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 Name <b>Margaret Shoptaugh</b> Address <b>St. Louis, Mo.</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>BRONCHIAL PNEUMONIA</b>										<b>2 wks.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b) <b>HYPERTENSIVE x ARTERIOSCLEROTIC HEART DISEASE</b>										<b>10 yrs</b>	
DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>										<b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>RESIDUALS OLD CEREBRO-VASCULAR THROMBOSIS</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 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.) <b>443 x</b>							
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>1955</b> to <b>SEPT. 23, 1962</b> and last saw her <sup>her</sup> alive on <b>Sept 22, 1962</b> Death occurred at <b>9:50 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <b>John Carrier, MD</b>						22b. ADDRESS <b>4401 Hampton - St Louis 29, Mo</b>			22c. DATE SIGNED <b>9-28-62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/26/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		23e. (State)			
24. FUNERAL DIRECTOR <b>White-Mullen Mortuary Ferguson Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 25 1962</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>					

Mr. Currier  
Mrs. Pic. Kuep  
Dec. 2-5-50  
St. Louis, Mo.

**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 Reinhold K. Lohmann

Licensed Embalmer No. 3395

P. O. Address St Louis 35 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.