

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036823

9199

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED SEP 28 1962

VS 300 Rev. 4/59	1	28129	3	4	3	5	1	6	7	1	8	2	9	10	11	12	52-0	13	52
DATE AMENDED		DATE AMENDED		DATE AMENDED		DATE AMENDED		DATE AMENDED		DATE AMENDED		DATE AMENDED		DATE AMENDED		DATE AMENDED		DATE AMENDED	
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS																			
INSTEAD OF																			
DOCUMENT																			
MEDICAL CERTIFICATION																			
BY AFFIDAVIT OF																			
SHOULD READ																			
ITEM NO.																			
USE BLACK INK OR TYPEWRITER RIBBON																			

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI			Length of stay in 1b 2 Days		c. CITY OR TOWN Madison, Illinois		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 802 Webster Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAUDE Middle CANZADY Last WADDY			4. DATE OF DEATH Month SEPTEMBER Day 21 Year 1962					
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/29/97	9. AGE (last birthday) 64	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Grand Tower, Illinois		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME FRANK WILSON			13b. MOTHER'S MAIDEN NAME ELIZABETH HINES			14. NAME OF HUSBAND OR WIFE SAMUEL WADDY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Madison, Ill. Samuel Waddy, 802 Webster Avenue,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUSPECTED MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4201								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) POST-OPERATIVE CATARACT EXTRACTION, RIGHT EYE					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 _____ 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 AUG. 6, 1951 to SEPT. 21, 1962 and last saw her alive on SEPT. 21, 1962 Death occurred at 11:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>E. J. McMillan, M.D.</i>				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 9/21/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/26/62	23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens of Memory		23d. LOCATION (City, town, or County) (State) Stookey Township, Illinois			
24. FUNERAL DIRECTOR <i>Marion O'Connell</i>				25. DATE RECD. BY LOCAL REG. SEP 24 1962		26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>		

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

Marionette Officer

Licensed Embalmer No. 5177

P. O. Address East St. Louis, Ill.

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.