

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036845

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9076

FILED SEP 28 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>20 Yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2010 Rutger</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2010 Rutger</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle Last <u>WATKINS</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>18,</u> Year <u>1962</u>			5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/14/70</u>		9. AGE (last birthday) <u>92</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (City and state or country) <u>Dresden, Tenn.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>			13a. FATHER'S NAME <u>Unk. Manning</u>			13b. MOTHER'S MAIDEN NAME <u>Emma (Unknown)</u>		
14. NAME OF HUSBAND OR WIFE <u>John (Deceased)</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT Address <u>Ethel Bruce, Rt. 1, Arnold, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Reprobated - Infected by Bacteria</u>											
DUE TO (c) <u>5-93 X</u>											
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 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 <u>Sept 1-1961</u> to <u>Sept 18-1962</u> and last saw her alive on <u>Sept 18-1962</u> Death occurred at <u>8 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>H. G. Moore MD</u> (Degree or title)						22b. ADDRESS <u>917 50th</u>			22c. DATE SIGNED <u>9-19-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moun t Hope</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>					
24. FUNERAL DIRECTOR <u>McLaughlin, 2301 Lafayette,</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>SEP 20 1962</u>		26. REGISTRAR'S SIGNATURE <u>Roald Smith, M.D.</u>					

One H. Moore
68 P.M.

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 James R. Chapman

Licensed Embalmer No. 4557

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.