

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036971

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2881

**FILED OCT 11 1962**

DO NOT WRITE ON THIS STUB

AMENDED

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

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Texas</b> b. COUNTY <b>Harris</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood</b>		Length of stay in 1b <b>3 days</b>	c. CITY OR TOWN <b>Houston</b> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>419 W. Alabama, Apt. 4</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>A</b> Last <b>CAUTHERS</b>			4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/3/93</b>
9. AGE (last birthday) <b>69</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>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Magnus Chemical Co.</b>	11. BIRTHPLACE (City and state or country) <b>Middletown, N. Y.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Will Cauthers</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Ruby Cauthers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Walter Cauthers, 419 W. Alabama, Houston</b>		Address <b>Texas</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>Cerebral hemorrhage</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Hypertension</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 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 <b>10-2-62</b> to <b>10-5-62</b> and last saw him alive on <b>10-5-62</b> Death occurred at <b>8:45 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Ervin Lemhardt, M.D.</b>		22b. ADDRESS <b>8460 Watson Rd. St. Louis,</b>	22c. DATE SIGNED <b>10-5-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/5/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Houston, Texas</b>
24. FUNERAL DIRECTOR <b>Louis H. Bopp, Inc. Kirkwood, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-5-62</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy, M.D.</b>

**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 *Fernis J. Myland Jr*

Licensed Embalmer No. 4512

P. O. Address Richwood, 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.