

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039949

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9693**

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 19 1962

VS 300
Rev. 4/59
1
2 20
3
4 1
5 0
6
7 0
8 2
9
10
11
12 63-0
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarinate Wd. Hosp.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4095 Robert Ave.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Ambrose						4. DATE OF DEATH Month Day Year Oct. 10, 1962					
5. SEX female		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Jul. 15, 1893		9. AGE (last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME John Hammann				13b. MOTHER'S MAIDEN NAME Mary Magsamen				14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO. unk		17. INFORMANT St. Louis, Mo. John Mary 4095 Robert Ave.					
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 4-5 days	
IMMEDIATE CAUSE (a) Cerebral thrombosis, extensive											
DUE TO (b) arteriosclerosis											
DUE TO (c) 332X											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease, auricular fibrillation										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 Oct. 9, 1962 to Oct 10, 1962 and last saw her/him alive on Oct 9, 1962		Death occurred at 3:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Walter P. Crumell M.D.		22b. ADDRESS 9764 Teasom Ferry, St. Louis 23		22c. DATE SIGNED 10/10			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-12-62		23c. NAME OF CEMETERY OR CREMATORY Ripa Convent Cem.		23d. LOCATION (City, town, or county) Lemay, Mo.		(State)			
24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.						25. DATE RECD. BY LOCAL REG. OCT 10 1962		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

63

Dr. Crowell

4th Floor

Surgeal Lounge

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 O. Hill

Licensed Embalmer No. 4347

P. O. Address 6322 So. Grand

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.