

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040080
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10065**

FILED NOV 1 1962

VS 300
Rev. 4/59

1

2 **205**

3

4 **0**

5 **1**

6

7 **0**

8 **1**

9 **+**

10

11

12 **90-3**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
		St. Louis			Missouri				St. Louis		
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION		308 Laurel		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 308 Laurel		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year	
William H CARRUTHERS			William	H	CARRUTHERS	October 19, 1962		October	19	1962	
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR				
Male	Caucasian		4-2-1920	42	Months		Days		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state and country)		12. CITIZEN OF WHAT COUNTRY					
Salesman		Surgical Supplies		St. Louis, Missouri		U.S.					
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE					
William H. Carruthers			Mary Gilligan			Virginia Carruthers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
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)											
Undetermined											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b)											
795.5											
DUE TO (c)											
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 type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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	Month, Day, Year								
		a.m.									
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 _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE			(Degree or title)			22b. ADDRESS			22c. DATE SIGNED		
Joseph M. Donnelly			M.D.			1300 Clark			10-20-62		
23a. BURIAL, CREMATION, OR DISPOSAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)			
Burial		10-22-1962		Calvary		St. Louis, Mo.					
FURNERAL DIRECTOR		ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
Donnelly		3840 Lindell		10-21-1962		Roan Smith, M.D.					

USE BLACK INK OR TYPEWRITER RIBBON

90

DEC 19 1962

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 *W. S. L. [Signature]*

Licensed Embalmer No. 4699
P. O. Address 3840 [Signature]

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.