

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

10017-62-040195  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10017

DO NOT WRITE ON THIS STUB

AMENDED

**FILED OCT 29 1962**

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Rev. 4/59

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DATE AMENDED  
INSTEAD OF  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
SHOULD READ  
ITEM NO.

DOCUMENT  
BY AFFIDAVIT OF  
*Dorothy C. Conroy, Web of Surgery*

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Oregon</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>92 days</b>	c. CITY OR TOWN <b>Thayer</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSURANCE <b>St. Louis Children's Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rural Route # 2</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>TINA</b> Middle <b>MARIE</b> Last <b>FETT</b>			4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>62</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-61</b>
9. AGE (last birthday) <b>1 yr.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Missouri West Plains,</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Jacob Fett</b>	
13b. MOTHER'S MAIDEN NAME <b>Wanda Benham</b>		14. NAME OF HUSBAND OR WIFE <b>Single</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>St. Louis 10, Missouri Ann Pryor 500 So. Kingshighway</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>CARDIAC ARREST UNKNOWN</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>759.0</b>
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 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 _____ 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>7-19-62</b> to <b>10-17-62</b> and last <sup>her</sup> <del>2:22</del> <b>10-17-62</b> Death occurred at <b>6:26 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Francis M Henderson MD</i>		22b. ADDRESS <b>500 So. Kingshighway St. Louis 10, Mo.</b>	22c. DATE SIGNED <b>10-17-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-19-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West Plains, Mo.</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe Inc., 4700 Washington,</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 19 1962</b>	26. REGISTRAR'S SIGNATURE <i>Paul Smith MD</i>

USE BLACK INK OR TYPEWRITER RIBBON

*Callor*

**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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.