

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040213

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District **1003** Registrar's No. **10358**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 1 1962

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

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
ST. LOUIS		ST. LOUIS				MO				ST. LOUIS		Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
2338 ^a MICHIGAN						2338 ^a MICHIGAN									
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			
NELLIE			FRENCH						OCT 27 1962						
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
FEMALE		WHITE				FEB 17 1883		79		Months		Days			
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 or country)				12. CITIZEN OF WHAT COUNTRY			
HOUSE WIFE								AUSTRIA HUNGARY				11-5-A			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
JOSEPH KOMRSKA				UNKNOWN				LOUIS FRENCH							
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			
NO				NONE				MARIE L NEMETZ				3925 ^e WYOMING			
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)												1 day			
DUE TO (b)												3 mo.			
DUE TO (c)												8 yrs.			
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.			
Pulmonary Abscess												<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 April 8-1948 to Oct 27-1962 and last saw her alive on October 26-62															
Death occurred at 9:00 p.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					
J. J. Calanave M.D.						2767 Leclair's Plaza 18 Mo				10-27-62					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)							
BURIAL		OCT 30, 1962		ST. PETER + PAUL CEM.				ST. LOUIS MO.							
24. FUNERAL DIRECTOR						25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE							
Thomas Xutis 2906 Gravois						OCT 29 1962		Moat Smith M.D.							

USE BLACK INK OR TYPEWRITER RIBBON

RECEIVED

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 Eleanor Pounce

Licensed Embalmer No. 3403

P. O. Address 2906 Groves

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.

Dr. John Pounce