

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

10376 - 62-040374  
STATE FILE NUMBER  
62-040374

DO NOT WRITE ON THIS STUB  
AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10376**

**FILED NOV 13 1962**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Louis, Mo</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Iowa</b> b. COUNTY <b>Polk</b>		c. CITY OR TOWN <b>Des Moines</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4827 Cupples Place</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1416 Goddard Court</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH E. JETT</b>						4. DATE OF DEATH Month Day Year <b>10-28-62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6-17-1892</b>		9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State of Iowa</b>		11. BIRTHPLACE (City and state or country) <b>Birmingham, Alabama</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>			
13a. FATHER'S NAME <b>Andrew Rogers</b>				13b. MOTHER'S MAIDEN NAME <b>Elizabeth Thomas</b>				14. NAME OF HUSBAND OR WIFE <b>dead</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>				16. SOCIAL SECURITY NO. <b>4</b>		17. INFORMANT <b>trell Smith 4827 Cupples Place</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Vascular Disease</b>											
DUE TO (c) <b>332X</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 type="checkbox"/> NO <input checked="" type="checkbox"/>		20. 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>7-30-62</b> to <b>10-28-62</b> and last saw her alive on <b>10-27-62</b> Death occurred at <b>7:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <b>R.E. Smith, M.D.</b>						22b. ADDRESS <b>2715 Union Avenue</b>			22c. DATE SIGNED <b>10-29-62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal (R.R)</b>		23b. DATE <b>10/31/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) <b>Des Moines, Iowa</b>		(State)			
24. FUNERAL DIRECTOR <b>Russell Funeral Home 5560 Etzel Ave</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 30 1962</b>		26. REGISTRAR'S SIGNATURE <b>Road Smith, 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

*H. Claude Hasdon*

Licensed Embalmer No.

*3489*

P. O. Address

*1123 N. Taylor Ave*

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.