

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040455

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9945**

FILED OCT 29 1962

VS 300
Rev. 4/59

1

2400-38

3

4 3

5 2

6

7 0

8 2

9

10

11

12 76-0

13

76

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

SHOULD READ

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		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
St. Louis		St. Louis		Byr239day		Mo.		St. Louis		St. Louis		1316 Albert St.		Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year				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	
Ida Mae Lewis				10 11 62				Female		Colored				5/9/1886		76		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 or country)				12. CITIZEN OF WHAT COUNTRY											
Unknown								Mo.				U. S. A.											
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
Washington Smith				Lucy				-----															
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											
								Chronic Hosp. 5800 Arsenal															
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) <u>Pneumonia?</u>												3 days.											
DUE TO (b) <u>Chemic Brain Syndrome due to cerebral</u>																							
DUE TO (c) <u>atherosclerosis 334XB</u>																							
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.											
① Diabetes mellitus ② Lues latent, treated.												<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 <u>3/16/59</u> to <u>10/11/62</u> and last saw ^{her} him alive on <u>10/11/62</u> Death occurred at <u>12:45 PM</u> 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											
<u>Arthur H. Duesch M.D.</u>						<u>Box 2000 St. Louis 19, Mo.</u>						<u>10-11-62</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)											
Rowland Aker Mortuary Service		10-31-1962		Anatomical Board				St. Louis, Mo.															
24. FUNERAL DIRECTOR						25. DATE RECD. BY LOCAL REG.						REGISTRAR'S SIGNATURE											
4104 Manchester Ave. St. Louis 10, Mo.						OCT 18 1962						<u>Rowland Smith, M.D.</u>											

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.