

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040739

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9641 STATE FILE NUMBER

**FILED OCT 19 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 <u>St. Louis</u>		Length of stay in 1b <u>D.O.A.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>8586 Riverview Blvd</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>G</u> Last <u>Sewell</u>			4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1962</u>			5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-26-1897</u>		9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>        </u> Days <u>        </u>		IF UNDER 24 HR Hours <u>        </u> Min. <u>        </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (City and state or country) <u>Anchorage, Kentucky</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13a. FATHER'S NAME <u>William F. Sewell</u>			13b. MOTHER'S MAIDEN NAME <u>Phoebe Russell</u>		
14. NAME OF HUSBAND OR WIFE <u>never married</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT Address <u>Mrs. Maul Sewell, 8586 Riverview Blvd</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>420.1</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
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"/>		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 <u>        </u> a.m. <u>        </u> p.m. Month, Day, Year <u>        </u>		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>        </u> to <u>        </u> and last saw her/him alive on <u>        </u> . Death occurred at <u>2:10 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Helen L. Taylor, Coroner</u>						22b. ADDRESS <u>1300 Clark Ave.</u>			22c. DATE SIGNED <u>10-9-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 10, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Math Hermann &amp; Son, Inc., 2161 E. Fair Ave St. Louis, 7, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 9 1962</u>		26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>					

USE BLACK INK OR TYPEWRITER RIBBON

**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 Hugh A. Burnley

Licensed Embalmer No. 4202

P. O. Address H. Loew, Inc.

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.