

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040870

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10559

FILED NOV 13 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>3yr. 3day</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>Chronic Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Little Flower Home</u> <u>18th and Victor</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>B.</u> Last <u>Weseman</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/1883</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Buchanan</u>		13b. MOTHER'S MAIDEN NAME <u>Louise</u>	
14. NAME OF HUSBAND OR WIFE <u>Bernard</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>-</u>		17. INFORMANT Address <u>Mrs. Mary Foulds 871 Cernicek Lane</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>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Supraventricular Tachycardia</u>			<u>3 hours</u>
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			<u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkinson's Disease 420.0</u>			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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>10/29/59</u> to <u>11/1/62</u> and last saw her alive on <u>11/1/62</u> Death occurred at <u>6:30 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dress or title) <u>Anneth Price</u>		22b. ADDRESS <u>5600 Arsenal St. Louis</u>	
22c. DATE SIGNED <u>11-2-62</u>		23. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/5/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Jos. A. Howard 1619 So. Grand</u>		25. DATE RECD. BY LOCAL REG. REGISTRAR'S SIGNATURE <u>NOV 3 1962</u> <u>Joan Smith, M.D.</u>	

**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

*John J. Hawkins*

Licensed Embalmer No.

*4108*

P. O. Address

*St Louis mo*

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.