

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010909

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

SL 29611 XC 30775

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9882**

FILED OCT 24 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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		Length of stay in 1b 33 HOURS	c. CITY OR TOWN EAST ST LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADM HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 507 N 38TH ST Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROY F WREN			4. DATE OF DEATH Month Day Year 10/14/62
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/21/98
9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY LABORER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) OMAHA, NEBR.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME FRANK WREN	
13b. MOTHER'S MAIDEN NAME MCDONAL, Edith		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address DANIEL W. WREN BRO 6530 HOBART, WELLSTON, MO.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY THROMBO-EMBOLI DUE TO (b) ARTERICOSCLEROSIS DUE TO (c) 450.0 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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. X attended the deceased from VA 10/13/62 to 10/14/62 and last saw him alive on 10/14/62 Death occurred 8:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>W. Schenk</i>	
22b. ADDRESS VAH, ST LOUIS, MO.		22c. DATE SIGNED 10/14/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-18-62	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR J.W. Clark F.H. 1125 Hodiamont Ave.		25. DATE RECD. BY LOCAL REG. OCT 16 1962	26. REGISTRAR'S SIGNATURE <i>Joan Smith, M.D.</i>

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 *Wm. J. L. [Signature]*

Licensed Embalmer No. 14511
P. O. Address *[Signature]*

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.