

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041019

STATE FILE NUMBER

Registration District No. 337 Primary Registration District No. 500 Registrar's No. 2929

1. PLACE OF DEATH
 a. COUNTY St. Louis
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch Length of stay in 1b 6 days
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hospital Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 5475 Cabanne Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Marian Middle H. Last Ghio 4. DATE OF DEATH Month Oct. Day 9 Year 1962
 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 7-29-83 9. AGE (last birthday) 79
 IF UNDER 1 YEAR Months 2 Days 10 IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME 10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE 11. BIRTHPLACE (City and state or country) Union, Missouri 12. CITIZEN OF WHAT COUNTRY U.S.A.
 13a. FATHER'S NAME Joseph Hawker 13b. MOTHER'S MAIDEN NAME Sarah Couch 14. NAME OF HUSBAND OR WIFE GEORGE Ghio
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. NONE 17. INFORMANT NORMANDY Mo. Address Mrs GARFORD HUME 5301 OLENE DR.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Pulmonary tuberculosis INTERVAL BETWEEN ONSET AND DEATH 24 years
 DUE TO (b) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) 1

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 Oct 3, 1962 to Oct 9, 1962 and last saw her alive on Oct 9, 1962
 Death occurred at 3:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Bernard Friedman, M.D. 22b. ADDRESS Robert Koch Hospital Koch Mo. 22c. DATE SIGNED 10-9-62

23a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT 23b. DATE 10-10-1962 23c. NAME OF CEMETERY OR CREMATORY OAK GROVE NIMSOLEHM 23d. LOCATION (City, town, or county) (State) St. Louis County Mo.

24. FUNERAL DIRECTOR LUPTON CHAPEL 7233 DELMAR BLVD. ADDRESS _____ 25. DATE RECD. BY LOCAL REG. 10-10-62 26. REGISTRAR'S SIGNATURE John B. M...

DO NOT WRITE ON THIS STUB

AMENDED

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Clarence H. Murray

Licensed Embalmer No. 4011

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.