

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041133

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3078

FILED NOV 5 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 St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights (17)		Length of stay in 1b 1 Day	c. CITY OR TOWN Crestwood
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9312 Buxton Dr.
3. NAME OF DECEASED (Type or print) First MRS. ANN Middle SCHAFFNER Last REED		4. DATE OF DEATH Month Oct. Day 23, Year 1962	
5. SEX F.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/23/1927
9. AGE (last birthday) 35		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) New York City, New York
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Paul A. Schaffner	
13b. MOTHER'S MAIDEN NAME Isabel Watkins		14. NAME OF HUSBAND OR WIFE Robert B. Reed	
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.	
17. INFORMANT Robert B. Reed		Address 9312 Buxton Dr. St. Louis (26)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive failure			INTERVAL BETWEEN ONSET AND DEATH 10 min.
DUE TO (b) Acute soft pneumonia			6 1/2 hr.
DUE TO (c) Acute endometritis due to prolonged rupture of membranes			9 1/2 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Aplastic anemia			PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" 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. I attended the deceased from June 4, 1962 to October 23, 1962 and last saw her alive on October 23, 1962 Death occurred at 1:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Frank J. Valach, M.D.		22b. ADDRESS 1617 S. Brentwood Blvd.	22c. DATE SIGNED 10/24/62
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE Oct. 26, 1962	23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, Inc. 6175 Delmar Blvd.		25. DATE RECD. BY LOCAL REG. 10-24-62	26. REGISTRAR'S SIGNATURE John M. Murphy, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

Frank J. Valach, M.D.
1617 S. Brentwood Blvd.
WO. 1 0700
Wed. 10:15 A.M. to 1 P.M.

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 J. Allen Davis

Licensed Embalmer No. 40893

P. O. Address Oct 23-1962

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.