

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041190
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3161

FILED NOV 5 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MANCHESTER MO Length of stay in lb		c. CITY OR TOWN ROCK HILL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PINE CREST NURSING HOME Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 538 N. ROCK HILL Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADDA Middle NANNETTE Last VAN		4. DATE OF DEATH OCTOBER 29, 1962	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH SEPT 12 80
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		9b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	9c. BIRTHPLACE (City and state or country) KENTUCKY
10a. FATHER'S NAME ALFRED FOX		10b. MOTHER'S MAIDEN NAME UNKNOWN	10c. NAME OF HUSBAND OR WIFE NONE
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) NO		11. SOCIAL SECURITY NO. UNKNOWN	11. INFORMANT C. L. Thomas Address 538 N. Rock Hill
12. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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
13. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	13b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) NONE	
14. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	14. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
15. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	15. CITY, TOWN, OR LOCATION	COUNTY	STATE
16. I attended the deceased from 10-20-62 to 10-29-62 and last saw her/him alive on 10-24-62 Death occurred at 6:00 p m on the date stated above, and to the best of my knowledge, from the causes stated.			
17. SIGNATURE (Degree or title) Allen M. Dearnley M.D.		17. ADDRESS 860. N. Woodlawn	17. DATE SIGNED 10-7-62
18. BURIAL, CREMATION, or REMOVAL (Specify)	18. DATE 10/16/62	18. NAME OF CEMETERY or CREMATORY Father Dicksons	18. LOCATION (City, town, or county) (State) Crestwood Mo
19. FUNERAL DIRECTOR J. J. Spangfeld	ADDRESS	20. DATE RECD. BY LOCAL REG 11-1-62	20. REGISTRAR'S SIGNATURE John Murphy M.D.

Missed to have
Keep this
333 N. ...

THE ...

Handwritten notes and signatures, including "The ...", "Missed to have", and "Keep this".

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 Headan J. ...

Licensed Embalmer No. 4243

P. O. Address 22 Euclid

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.

Handwritten scribbles and marks in the bottom left corner.