

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043810

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 267

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 21 1962

VS 300
Rev. 4/59

0920
0920

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>COTTLEVILLE</u>		Length of stay in 1b <u>DOA</u>	c. CITY OR TOWN <u>COTTLEVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL <u>St. Joseph's Hosp.</u> INSTITUTION <u>400 OAK ST.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>400 OAK ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LAVERNE</u> Last <u>MERK</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 16, 1937</u>
9. AGE (last birthday) <u>25</u>		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) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>ASHLAND, MO</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>SAMUEL MORRIS</u>	
13b. MOTHER'S MAIDEN NAME <u>LORENE WOODS</u>		14. NAME OF HUSBAND OR WIFE <u>JERRY LYNN MERK</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. _____	17. INFORMANT Address <u>JERRY LYNN MERK, COTTLEVILLE, MO.</u>
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>mucus cyst, fourth ventricular</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>MOS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>air embolisms throughout the body</u>		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 type="checkbox"/> NO <input checked="" 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.) <u>Woman fell out of bed after</u>	
20c. TIME OF INJURY Hour <u>12:45</u> a.m. <u>PM</u> Month, Day, Year <u>11/5/62</u>	apparent slight convulsion.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Cottleville, St. Charles, Mo.</u>	COUNTY STATE
21. I attended the deceased from <u>held inquest</u> to <u>Nov. 7, 1962</u> and last saw her <u>him</u> alive on _____ Death occurred at <u>2445 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James R. Amalongo</u> Coroner		22b. ADDRESS <u>12 Cunningham St. Charles, Mo.</u>	22c. DATE SIGNED <u>11/7/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8 NOV. 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. CHARLES MEMORIAL GARDENS</u>	23d. LOCATION (City, town, or county) (State) <u>ST. CHARLES MO.</u>
24. FUNERAL DIRECTOR <u>PRINSTER-BAUE F.H. INC.</u>	ADDRESS <u>ST. CHARLES</u>	25. DATE RECD. BY LOCAL REG. <u>11-7-62</u>	26. REGISTRAR'S SIGNATURE <u>Mareella Wilson</u>

JUL 19 1963

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 Frederic M. Bane

Licensed Embalmer No. 4607

P. O. Address St. Charles, 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.