

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043947

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11541**

FILED DEC 7 1962

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	1	
2							217	
3							1	
4							2	
5							0	
6							2	
7							0	
8							2	
9							0	
10							0	
11							0	
12							75-0	
13							75	

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY															
		<b>ST. LOUIS, MO</b>				<b>MO.</b>																	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>													
<b>ST. LOUIS CITY HOSP. #1.</b>						<b>4100<sup>e</sup> BOTANICAL AVE</b>																	
3. NAME OF DECEASED (Type or print)						First		Middle		Last		4. DATE OF DEATH		Month		Day		Year					
<b>ELIZABETH</b>						<b>BECKER</b>						<b>NOV. 29, 1962</b>											
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR											
<b>FEMALE</b>		<b>WHITE</b>				<b>FEB 22 1871</b>		<b>91</b>															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY											
<b>HOUSE WORK</b>				<b>AT HOME</b>				<b>ST. LOUIS, MO.</b>				<b>U-S-A</b>											
13a. FATHER'S NAME						13b. MOTHER'S MAIDEN NAME						14. NAME OF HUSBAND OR WIFE											
<b>HENRY MUELLER</b>						<b>LENA SUESS</b>						<b>ALOYSIUS BECKER</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address											
<b>NO</b>						<b>NONE</b>						<b>HELEN BECKER 4100<sup>e</sup> BOTANICAL AVE</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a)																							
<b>Aspiration Pneumonia</b>																							
DUE TO (b)																							
<b>Cerebral Vascular Accident</b>																							
DUE TO (c)																							
<b>Generalized Arteriosclerosis</b>																							
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.													
										<b>331X</b>													
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.)															
20c. TIME OF INJURY		Hour		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 <b>11/20/62</b> to <b>11/29/62</b> and last saw her/him alive on <b>11/29/62</b>																							
Death occurred at <b>1:05 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE						Degree or title						22b. ADDRESS						22c. DATE SIGNED					
<b>John Mc Donough M.D.</b>												<b>1515 LAFAYETTE AVE</b>						<b>11/29/62</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)							
<b>BURIAL</b>				<b>DEC 3, 1962</b>				<b>ST. PETER + PAUL CEM.</b>				<b>ST. LOUIS</b>				<b>MO.</b>							
24. GENERAL DIRECTOR						ADDRESS						25. DATE RECD. BY LOCAL REG.						26. REGISTRAR'S SIGNATURE					
<b>Thomas Hutis</b>						<b>2906 Gravois</b>						<b>DEC 1- 1962</b>						<b>Roald Smith, M.D.</b>					

MC DONOUGH 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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.