

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044181

STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. **10772**

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962							
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1231 Goodfellow Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1231 Goodfellow Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Joseph B. Ernst	4. DATE OF DEATH Month Day Year Nov. 8, 1962						
5. SEX Male	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/22/1887	9. AGE (last birthday) 74	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) Shipping Clerk	10b. KIND OF BUSINESS OR INDUSTRY Maul Grocer	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.				
13a. FATHER'S NAME Frank Esselman		13b. MOTHER'S MAIDEN NAME Elizabeth Ernst		14. NAME OF HUSBAND OR WIFE			
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. [REDACTED]	17. INFORMANT A Louise Kaltenback Goodfellow Address 1231			
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) generalized arteriosclerosis with DUE TO (c) arteriosclerosis heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 450.0					INTERVAL BETWEEN ONSET AND DEATH 24Hrs		
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.) 450.0		
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 9-28-61 to 11-8-62 and last saw ^{him} alive on 11-8-62 Death occurred at 3PM 11-8-62 m on the date stated above and to the best of my knowledge, from the causes stated. DREWITT BAILEY, M.D.							
22a. SIGNATURE (Degree or title) Drewitt Bailey M.D.			22b. ADDRESS 6356 CLAYTON ROAD ST. LOUIS 17, MO.		22c. DATE SIGNED 11-9-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-10-62	23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. CITY, TOWN, OR COUNTY (State) St. Louis Co. Mo.		
24. FUNERAL DIRECTOR ADDRESS Lupton Chapel Inc. 7233 Delmar Blvd.			25. DATE RECD. BY LOCAL REG. NOV 9 1962		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

VS 300 Rev. 4/59
 1
 2 **2068**
 3
 4 **0**
 5 **0**
 6
 7 **0**
 8 **2**
 9
 10
 11
 12 **90-0**
 13
90

USE BLACK INK OR TYPEWRITER RIBBON

City
472 Brennan Bailey
1356 Clough Ave
Princeton 3834
1-6 PM

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.