

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044549

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District 1003 Registrar's No. 10769 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED NOV 19 1962**

VS 300  
Rev. 4/59

1  
2 20  
3  
4 1  
5 2  
6  
7 0  
8 2  
9  
10  
11  
12 90-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6105 Pershing.</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6105 Pershing</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kathryn LUCAS</b>						4. DATE OF DEATH Month <b>November</b> Day <b>8,</b> Year <b>1962</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-29-80</b>		9. AGE (last birthday) <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>			
13a. FATHER'S NAME <b>Michael G. Lucas</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>John F. Lucas (Deceased)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Adele Quinn, 6105 Pershing</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arterio sclerosis</b> <b>Semility</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>450.0</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
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			
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 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> 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 <u>19 50</u> to <u>11/7/1962</u> and last saw her alive on <u>11/7/62</u> Death occurred at <u>1:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>William O. Mowley M.D.</i>						22b. ADDRESS <i>231 W. Ballalwood Dr.</i>			22c. DATE SIGNED <i>11/9/62</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-10-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>				23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>			
24. FUNERAL DIRECTOR <i>Arthur J. Donnelly</i> ADDRESS <b>3840 Lindell Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 9 1962</b>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>					

90

**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. 4699

P. O. Address 3840 Judd

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.