

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044886

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11039** STATE FILE NUMBER

FILED NOV 26 1962

VS 300 Rev. 4/59

1
2 **215**
3
4 **0**
5 **1**
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

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Length of stay in lb | | 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"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4147 WALSH | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 4147 WALSH | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle SLAMA Last | | | 4. DATE OF DEATH Month Nov. Day 15 Year 1962 | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH MARCH 2 1895 | | 9. AGE (last birthday) 77 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) SHOE CUTTER | | 10b. KIND OF BUSINESS OR INDUSTRY WOLFF TOBERSHNECA | | 11. BIRTHPLACE (City and state or country) ST. LOUIS MO. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |
| 13a. FATHER'S NAME JOHN SLAMA | | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | | 14. NAME OF HUSBAND OR WIFE VERONICA SLAMA | | | | | |
| 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. | | 17. INFORMANT Address VERONICA SLAMA 4147 WALSH | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rectum | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8-11-61 | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | | | 154X | |
| 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 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 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 8-11-61 to 11-14-62 and last saw her/him alive on 11-14-62 Death occurred at 230 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Engene H. Edde M.D. | | | | 22b. ADDRESS 4971 Chippewa St. | | | | 22c. DATE SIGNED 11-16-62 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE Nov. 17 1962 | | 23c. NAME OF CEMETERY OR CREMATORY A.A. PETERY PAUL | | 23d. LOCATION (City, town, or county) (State) ST. LOUIS MO. | | | | | |
| 24. FUNERAL DIRECTOR Thomas Kute | | ADDRESS 2906 Granada | | 25. DATE RECD. BY LOCAL REG. NOV 17 1962 | | 26. REGISTRAR'S SIGNATURE Roan Smith, M.D. | | | | | |

1934

Dr. Edlle
4971 Chickadee

12-3

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gravois

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.