

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045137

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3122

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962	
1. PLACE OF DEATH a. COUNTY <u>St. Louis Co.</u> b. CITY (If outside corporate limits, give TOWNSHIP or NEIGHBORHOOD) <u>RICHMOND HEIGHTS CLAYTON, MO.</u> Length of stay in 1b <u>12 HRS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____ c. CITY OR TOWN <u>ST. LOUIS.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>8442 Edna Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>TODD</u> Middle <u>DANIEL</u> Last <u>ARTEAGA</u>	
4. DATE OF DEATH Month <u>10</u> - Day <u>28</u> - Year <u>62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAUCASIAN</u>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <u>10-28-62</u>	
9. AGE (last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours <u>12</u> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (City and state or country) <u>CLAYTON, MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>ELDON F. ARTEAGA</u>	
13b. MOTHER'S MAIDEN NAME <u>CAROLYN ANN VENNEMAN</u>	
14. NAME OF HUSBAND OR WIFE <u>NONE</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. <u>NONE</u>	
17. INFORMANT <u>ELDON ARTEAGA</u> Address <u>8442 EDNA AVE.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY ATELECTASIS</u> DUE TO (b) <u>IMMATUREITY</u> DUE TO (c) <u>NONE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>NONE</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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.	
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>10-28-62 (BIRTH)</u> to <u>10-28-62 (DEATH)</u> and last saw her/him alive on _____ Death occurred at <u>1:30PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Paul John Ketter MD</u> (Degree or title)	
22b. ADDRESS <u>#16 Hampton Village Plaza, St. Louis 9, Mo.</u>	
22c. DATE SIGNED <u>10-29-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>10/30/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>	
24. FUNERAL DIRECTOR <u>MORRELL MORTUARY</u> ADDRESS <u>3710 No. GRAND</u>	
25. DATE RECD. BY LOCAL REG. <u>10-29-62</u>	
26. REGISTRAR'S SIGNATURE <u>John E. [Signature]</u>	

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DATE AMENDED 9-2-
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Not Embalmed

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.