

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045487

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3390

FILED DEC 3 1962

VS 300
Rev. 4/59

4013
2 4013
3
4 1
5 2
6
7 1
8 2
9 201X
10
11
12 90-2
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 St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Florissant		Length of stay in 1b 4 1/2 years	c. CITY OR TOWN Florissant Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 250 St. Catherine St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 250 St. FERDINAND St. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CATHERINE ^{First} MARGARET ^{Middle} VALERIUS ^{Last}			4. DATE OF DEATH Month November Day 18 , Year 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY XXXXXX	9. AGE (last birthday) 67
11. BIRTHPLACE (City and state or country) Elwood, Indiana		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Peter Bayer		13b. MOTHER'S MAIDEN NAME Mathilda Nenninger	14. NAME OF HUSBAND OR WIFE Deceased
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. None	17. INFORMANT Hubert C. Valerius, 865 N. Florissant, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Paralysis DUE TO (b) Metastatic Carcinomatosis DUE TO (c) Noddykin's Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH seconds weeks years
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	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 Oct. 1961 to 11-18-1962 and last saw her alive on 11-18-1962 Death occurred at 9:05 PM CST m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert L. Clark, D.O.</i> (Degree or title)		22b. ADDRESS 1735 N. Florissant Rd. Florissant Mo.	22c. DATE SIGNED 11-20-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-21-1962	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) Edwardsville Ill.
24. FUNERAL DIRECTOR The Florissant Mortuary, Florissant, Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 11-20-62	26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>

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

Gene A. Sutcliffe

Licensed Embalmer No. 4966

P. O. Address FLORISSANT, NW

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.