

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045502

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3430

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

14005
240392

3

4 1

5 2

6

7 1

8 2

9491X

10

11

1246-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Hgts.		c. CITY OR TOWN St. John	
Length of stay in lb 1 day		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hosp		d. STREET ADDRESS (If outside, give location) 3628 Brown Rd	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MABEL WERNER			4. DATE OF DEATH 11/24/62
First MABEL Middle WERNER Last WERNER		Month 11 Day 24 Year 62	
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 2/27/1897
9. AGE (last birthday) 70		IF UNDER 1 YEAR IF UNDER 24 HR	
		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (City and state or country) Evansville, Ind.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME David Sparks		13b. MOTHER'S MAIDEN NAME Mary Stone	
14. NAME OF HUSBAND OR WIFE Edward Werner (dec'd)			
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 Max Werner 3357 Marshall St. John, MO		Address	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Artery Heart Disease			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 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>1960</u> to <u>24 Nov 62</u> and last saw her alive on <u>24 Nov 62</u> Death occurred at <u>5:25 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Louise Collette J. M.D.		22b. ADDRESS 1211 S Brentwood	
22c. DATE SIGNED 11/24/62			
23a. BURIAL INFORMATION, REMOVAL (Specify) Removal	23b. DATE 11/26/62	23c. NAME OF CEMETERY OR CREMATORY Calvary	
23d. LOCATION (City, town, or county) St. Louis Mo			
24. FUNERAL DIRECTOR Ortmann F. Home 9222 Lackland Overland Mo		25. DATE RECD. BY LOCAL REG. 11-24-62	
ADDRESS		26. REGISTRAR'S SIGNATURE John M. Murphy M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

X
X

(b'osb) m... ..

OM,

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 Sam Stepanovic

Licensed Embalmer No. 5088

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.