

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-048050

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 2058 Registrar's No. 295

FILED DEC 21 1962

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u>		c. CITY OR TOWN <u>ST. CHARLES</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH'S Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>1005 CUNNINGHAM</u>	
3. NAME OF DECEASED (Type or print) First <u>SCOTT</u> Middle <u>ANTHONY</u> Last <u>ARMBRUSTER</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>12-6-1962</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) Months <u>1</u> Days <u>15</u> Hours <u>12</u>
11. BIRTHPLACE (City and state or country) <u>ST. CHARLES MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>ROBERT ANTHONY ARMBRUSTER</u>		13b. MOTHER'S MAIDEN NAME <u>LUCILLE ROSE JACOBI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>LUCILLE JACOBI ARMBRUSTER</u>		Address	
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>Myeloid leukemia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>12-6-62</u> to <u>12-7-62</u> and last saw her alive on <u>12-7-62</u> Death occurred at <u>9 52 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James H. Nelson</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>207 N. FIFTH ST. ST. CHARLES MO</u>	
22c. DATE SIGNED <u>12-7-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-8-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO</u>
24. FUNERAL DIRECTOR <u>James H. Nelson</u>		25. DATE RECD. BY LOCAL REG. <u>12-8-62</u>	
26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

10928

20928

3

4 0

5 0

6

7 0

8 1

97730

10

11

12 1-0

13 4-0

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

James L. Steward

Licensed Embalmer No. 3817

P. O. Address The Benevolent Co

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.