

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12208-62-048136
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED JAN 2 1967

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Rev. 4/59

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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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>Bowling Green</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>215 So. Cuivre</u>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>S.</u> Last <u>Andrews</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/1882</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Lykins, Penn.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>William B. Bateman</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Ann Ball</u>		14. NAME OF HUSBAND OR WIFE <u>G.T. Andrews</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 Address <u>Mrs. A.A. Vandivort, Dallas, Texas</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>CEREBRAL VASCULAR ACCIDENT</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u>
DUE TO (b) <u>INTERTROCHANTERIC FRACTURE RIGHT HIP</u>			<u>5 weeks</u>
DUE TO (c) <u>904.7-45</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>TERMINAL PNEUMONIA</u>			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 checked="" 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.) <u>Pt. slipped & fell in McMillan Hospital</u>	
20c. TIME OF INJURY Hour <u>9-9:30</u> a.m. _____ p.m. _____ Month, Day, Year <u>11 12 62</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>McMillan Hospital 18</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Louis Missouri</u>	
21. I attended the deceased from <u>11/12/62</u> to <u>12/15/62</u> and last saw her/him alive on <u>12/15/62</u> Death occurred at <u>2:35 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>F.R. Bradley, M.D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	
22c. DATE SIGNED <u>12/15/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vandalia Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Vandalia, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.,</u>		25. DATE RECD. BY LOCAL OFF. <u>DEC 19 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH

3-23-64

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address S. R.

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.