

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048317

STATE FILE NUMBER

Registration District No. **318** Primacy Registration District No. **1003** Registrar's No. **12338**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 2 1963

VS 300
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

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Length of stay in lb | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hosp | | d. STREET ADDRESS (If outside, give location) 6024 Fyler | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First August Middle M Last Favre | | | 4. DATE OF DEATH Month 12 Day 22 Year 62 |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/5/97 |
| 9. AGE (last birthday) 65 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Repairman | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Rolla, Mo |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME Morris Favre | |
| 13b. MOTHER'S MAIDEN NAME Adwline Roth | | 14. NAME OF HUSBAND OR WIFE Emily Favre | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI | | 16. SOCIAL SECURITY NO. unk | 17. INFORMANT Emily Favre 6024 Fyler Ave. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Abs. Atherosclerotic Coronary Thrombosis | | | |
| DUE TO (c) 4201 | | | |
| 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 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. | 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 12-20-61 to 12-22-62 and last saw her/him alive on 12-21-62 Death occurred at 8:00 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Carol J. Perry MD (Degree or title) | | 22b. ADDRESS 1817 Pryor Highway | 22c. DATE SIGNED 12-23-62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 12/24/62 | 23c. NAME OF CEMETERY OR CREMATORY National Cem. | 23d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo |
| 24. FUNERAL DIRECTOR Edward Fendler 5611 South Grand Blvd. | | 25. DATE RECD. BY LOCAL REG. DEC 24 1962 | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. |

USE BLACK INK OR TYPEWRITER RIBBON

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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 Leo J. Bussard

Licensed Embalmer No. 3989

P. O. Address St. Louis Mo

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.