

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048457

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 12632

FILED JAN 10 1962

VS 300 Rev. 4/59	DATE AMENDED				
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Coles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Charleston	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Last Jeffries 1900		4. DATE OF DEATH Month December Day 26 , Year 1962	
5. SEX Female	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 12/14/1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 63 62
11a. FATHER'S NAME Russart Charles Kuffart		11b. BIRTHPLACE (City and state or country) Eddyville, Iowa	
13a. FATHER'S NAME Russart Charles Kuffart		13b. MOTHER'S MAIDEN NAME Eva Moran	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Jefferies, Charleston, Illinois.		17. 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) Concomitant DUE TO (b) Cu of Ovary DUE TO (c) 1750 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 Month
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"/>	
20c. TIME OF INJURY Hour 8:30 pm Month, Day, Year 12-29-62		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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.)	
21. I attended the deceased from 7-20-62 to 12-26-62 and last saw her alive on 12-26-62 Death occurred at 8:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.		20f. CITY, TOWN, OR LOCATION Charleston, Ill.	
22a. SIGNATURE <i>Carl J. Roe M.D.</i>		22b. ADDRESS <i>Rt 1 Highway</i>	
22c. DATE SIGNED 12-28-62		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-29-62	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Charleston, Ill.	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. DEC 31 1962	
26. REGISTRAR'S SIGNATURE <i>Loal Smith, M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

Charles Kuffart
12/14/99 & 63
DOCUMENT
Own birth record
Charles Russart
12/14/1900 & 62
Funeral Director

MEDICAL CERTIFICATION

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 Harry E. Monroe

Licensed Embalmer No. 4495

P. O. Address St. Louis

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.

REC'D AT THE OFFICE OF THE COMMISSIONER OF HEALTH, ST. LOUIS, MO. JAN 14 1900

100