

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12341-62-048717
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 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>3 Weeks</u>	c. CITY OR TOWN <u>Brentwood Mo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>17 York Dr</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances S. Scherrer</u>			4. DATE OF DEATH Month Day Year <u>Dec 21 62</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>7-28-78</u>	9. AGE (last birthday) <u>84</u>	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) <u>In Retired - POKOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance Broker</u>		11. BIRTHPLACE (City and state or country) <u>VERMONT</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>George Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Fanny Dickinson</u>		14. NAME OF HUSBAND OR WIFE <u>Leon B.</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>[Redacted]</u>		17. INFORMANT Address <u>Leon B. Sherrer 17 York Dr Brentwood 17</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 da</u>
Conditions (if any) which gave rise to above (a), starting first under-lying cause last. DUE TO (b) <u>Fracture in hip</u>			
DUE TO (c) <u>Arteriosclerotic (vascular) disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2-74-8</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 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>333</u>
20c. TIME OF INJURY Hour a.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.) <u>3B</u>	20f. CITY, TOWN, OR LOCATION <u>3B</u>	COUNTY	STATE
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21. I attended the deceased from Dec 8 1962 to Dec 21 1962 and last saw her alive on Dec 20 1962
Death occurred at 9:40 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. Debaugh M.D.</u>	22b. ADDRESS <u>Webster Groves Mo</u>	22c. DATE SIGNED <u>12/23/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12 - 24 62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Normandy Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Bobo Chapel 10610 Manchester</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 24 1962</u>	26. REGISTRAR'S SIGNATURE <u>Leon Smith, M.D.</u>
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USE BLACK INK OR TYPEWRITER RIBBON

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 *Thomas J. Myland Jr*

Licensed Embalmer No. 4512

P. O. Address Highwood, 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.