

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048732

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12262 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 2 1962

VS 300
Rev. 4/59

1

2 216

3

4 1

5 2

6

7 1

8 2

9

10

11

12 90-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3517^A CONNECTICUT</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3517^A CONNETICUT</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)						First <u>MATTIE</u> Middle <u>SELDEN</u> Last			4. DATE OF DEATH Month <u>DEC.</u> Day <u>19</u> Year <u>1962</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>JULY 23 1973</u>		9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months Days 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>HOME</u>		11. BIRTHPLACE (City and state or country) <u>TENNESSEE</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>BOND</u>				13b. MOTHER'S MAIDEN NAME <u>MARGARET CASAN</u>				14. NAME OF HUSBAND OR WIFE <u>ALBERT SELDEN</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 <u>DON SELDEN 3517^ACONNECTICUT</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>cerebral thrombosis causing stroke 3 days</u>	
DUE TO (c) <u>420.0</u>											
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 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.)							
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>Jan 19 60</u> to <u>Jan 19 - 1962</u> and last saw her/him alive on <u>Jan 19 - 1962</u> Death occurred at <u>10:14 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>Ralph Berglund</u> (Degree or title)						22b. ADDRESS <u>32038 Grand</u>			22c. DATE SIGNED <u>1/21/62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>DEC. 21 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST. MARCUS</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>					
24. FUNERAL DIRECTOR <u>Thomas Kuttis 2906 Grand</u>				25. DATE RECD. BY LOCAL REG. <u>DEC 21 1962</u>		26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>					

RR Rating 3203 Standard
RR 3-7857

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 Eleanore Province

Licensed Embalmer No. 3403

P. O. Address 2906 Jewett

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.