

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048988

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3633

DO NOT WRITE
ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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>Mattese</u>		c. CITY OR TOWN <u>Mattese</u>	
Length of stay in 1b <u>6 yrs</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4922 Mt. Royal Rd.</u>		d. STREET ADDRESS (If outside, give location) <u>4922 Mt. Royal Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>A.</u> Last <u>HACKMAN</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</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>6/15/1873</u>
9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
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>Clinton Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Adamson</u>		13b. MOTHER'S MAIDEN NAME <u>Sally Lindsey</u>	
14. NAME OF HUSBAND OR WIFE <u>Frederick (Deceased)</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> </u>		17. INFORMANT <u>M.F. Hackman</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>A. I. H. D.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>hypertension</u> DUE TO (c) <u>Gen. Ar. P. Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>44 yrs.</u> <u>64 yrs.</u> <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </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> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>		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> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>	
20g. COUNTY <u> </u>		20h. STATE <u> </u>	
21. I attended the deceased from <u>Mar. 1956</u> to <u>Jan. 12</u> and last saw her alive on <u>Jan. 11, 62</u> . Death occurred at <u>4:AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr. E. H. Koch M.D.</u>		22b. ADDRESS <u>1504 Y. Hance Blvd.</u>	
22c. DATE SIGNED <u>12.12.62</u>		22d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/14/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Mausoleums</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>John L. Ziegenhein & Sons 7027 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>12-14-62</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		27. DATE SIGNED <u> </u>	

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 _____

Licensed Embalmer No. 4863

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.