

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049130

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3692

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963

VS 300  
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>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		c. CITY OR TOWN <u>St. Clair</u>	
Length of stay in lb <u>DAYS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>St. Clair</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Fern</u> Middle <u>Starke</u> Last <u>S</u>			4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>62</u>
5. SEX <u>Female</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>8-15-22</u>
9. AGE (last birthday) <u>39</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <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>General</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Haavey Blackwell</u>	
13b. MOTHER'S MAIDEN NAME <u>Puscilla Hendrix</u>		14. NAME OF HUSBAND OR WIFE <u>Raymond Starke</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>No</u>	
17. INFORMANT <u>Puscilla Hendrix</u>		Address <u>  </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>Cardio-vascular + Respiratory failure</u> DUE TO (b) <u>Cerebral concussion</u> DUE TO (c) <u>Trauma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>  </u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>12-2-62</u> to <u>12-17-62</u> and last saw her/him alive on <u>12-17-62</u> Death occurred at <u>4:50 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>L.A. Sememan M.D.</u> (Degree or title)		22b. ADDRESS <u>601 So. Brentwood-Clayton-Mo.</u>	22c. DATE SIGNED <u>12/17/62</u> (State)
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>12-20-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUND</u>	23d. LOCATION (City, town, or county) <u>ST. CLAIR, MO</u>
24. FUNERAL DIRECTOR <u>Kitchell F.W.</u> ADDRESS <u>St. Clair, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-17-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

JAN 11 1993

**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

*Sherwood W. Mitchell*

Licensed Embalmer No.

3873

P. O. Address

St. Clair, 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.