

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049158

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3853

FILED JAN 10 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Creve Coeur		Length of stay in 1b 2 days	c. CITY OR TOWN Frontenac
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Green Valley Nurs. Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10419 Conway Rd.
3. NAME OF DECEASED (Type or print) First Marie Middle Emma Last Werner		4. DATE OF DEATH Month Dec. Day 30 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-17-78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Karl Burchardt		13b. MOTHER'S MAIDEN NAME Christine Hartje	14. NAME OF HUSBAND OR WIFE Ernst Curt (dcd).
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Carl Werner 10419 Conway Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema			INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Intra-cranial Hemorrhage			2 wks.
DUE TO (c) Arteriosclerosis Generalized			5-10 yrs.
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 Dec 26, 1962 to Dec 30, 1962 and last saw her ^{her} _{him} alive on Dec 26, 1962 . Death occurred at 11 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. H. J. Murphy MD		22b. ADDRESS 11745 Olive St RD	22c. DATE SIGNED Jan 2, 1963
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-2-1963	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Park Cem.	23d. LOCATION (City, town, or county) (State) Wellston, Mo.
24. FUNERAL HOME ADDRESS BAUMANN BROS. INC. FUNERAL HOME 2504 WOODSON ROAD OVERLAND 14, MISSOURI		25. DATE RECD. BY LOCAL REG. 1-2-63	26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

STATE OF OHIO
DEPARTMENT OF HEALTH

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 David E. Gibson

Licensed Embalmer No. 3454

P. O. Address W R 14 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.