

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049166

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 3655

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1962

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>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		Length of stay in lb <u>33 Years</u>	c. CITY OR TOWN <u>Webster Groves</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>314 E. Lockwood Blvd.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>314 E. Lockwood Blvd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Bower</u> Last <u>Woodward</u>			4. DATE OF DEATH Month <u>December</u> Day <u>13</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>5-27-1872</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>Sell</u>	9. AGE (last birthday) <u>90</u> IF UNDER 1 YEAR: Months <u>13</u> Days <u>1962</u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>
11a. BIRTHPLACE (City and state or country) <u>Olney, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Bower</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Martin</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>		17. INFORMANT <u>Hazel Doster 314 E. Lockwood Blvd.</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>Cerebral Hemorrhage</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <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			INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u> <u>8 yrs</u>
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 <u> </u> a.m. <u> </u> p.m. 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.)		20f. CITY, TOWN, OR LOCATION COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>1942</u> to <u>12/13/62</u> and last saw her alive on <u>12/13/62</u> Death occurred at <u>12/13/62 2:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Carl Brand MD</u> (Degree or title)		22b. ADDRESS <u>Webster Groves Mo</u>	
22c. DATE SIGNED <u>12/14/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
<u>REMOVED</u>		<u>12-15-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u> (State)	
24. FUNERAL DIRECTOR - GEBBER <u>COLONIAL CHAPEL</u> <u>WEBSTER GROVES 19, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>12-15-62</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</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 Harvey Stahl

Licensed Embalmer No. 4596

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.