

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049173

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 319

Primary Registration District No. _____

Registrar's No. 68

STATE FILE NUMBER

FILED JAN 7 1962

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| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT | MEDICAL CERTIFICATION | BY AFFIDAVIT OF | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
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| 1. PLACE OF DEATH a. COUNTY <u>ST. GENEVIEVE</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. GENEVIEVE</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JACKSON T.S.</u> | | c. CITY OR TOWN <u>BLOOMDALE</u> | |
| Length of stay in 1b <u>15 YRS</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BLOOMDALE STAR ROUTE</u> | | d. STREET ADDRESS (If outside, give location) <u>STAR ROUTE</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle _____ Last <u>MIX</u> | | | 4. DATE OF DEATH Month <u>DEC</u> Day <u>20</u> Year <u>1962</u> |
| 5. SEX <u>MALE</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>2/12/89</u> |
| 9. AGE (last birthday) <u>73</u> | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TRUCK DRIVER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT SEA</u> | 11. BIRTHPLACE (City and state or country) <u>U.S.A.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME <u>UNKNOWN</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>ABBEY MIX</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. _____ | |
| 17. INFORMANT <u>FAMILY BIBLE</u> | | Address _____ | |
| 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>ACUTE MYOCARDIAL INFARCTION</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u> <u>5 YEARS</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CORONARY ARTERY DISEASE</u> | | | |
| DUE TO (c) <u>ARTERIO SCLEROTIC HEART DISEASE</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 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>12-20-62</u> to <u>12-20-62</u> and last saw ^{her} him alive on <u>12-20-62</u> Death occurred at <u>12:20 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | | 22b. ADDRESS <u>St. Genevieve, Mo</u> | |
| 22c. DATE SIGNED <u>12-22-62</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>12/22</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO, MO</u> |
| 24. FUNERAL DIRECTOR <u>Leo E. Baskin</u> ADDRESS <u>St. Genevieve Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>29 Dec 1962</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

USE BLACK INK OR TYPEWRITER RIBBON

JAN 9 1967

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

Adrian J. Ehlke

Licensed Embalmer No. 4740

P. O. Address Sta. Denerville 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.