

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004176
795 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **795**

FILED JAN 31 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year			
a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	a. STATE		b. COUNTY	First Middle Last		Month Day Year			
St. Louis		St. Louis		2 Months	Illinois		Madison	Hazel Sanders Stubbs		January 23 1963			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		14. NAME OF HUSBAND OR WIFE		
St. John's Hospital		923 St. Louis Street		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Edwardsville		Louisiana, Missouri		USA		Arthur H. Stubbs		
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR	
Female		White				3/18/89		73		10 Months 5 Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)			12. CITIZEN OF WHAT COUNTRY				
Housewife				Home		Louisiana, Missouri			USA				
13a. FATHER'S NAME					13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE					
Sanders					Jane Bailey			Arthur H. Stubbs					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)					16. SOCIAL SECURITY NO.			17. INFORMANT					
no								Mr. Harrison B. Stubbs 1015 E. St. Louis St. Edwardsville, Ill.					
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)												8 Yrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
DUE TO (b)													
DUE TO (c)													
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 <u>Jan 1958</u> to <u>1-23-63</u> and last saw her alive on <u>1-22-63</u>													
Death occurred at <u>10-15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE						22b. ADDRESS			22c. DATE SIGNED				
<u>Carl J. Reis MD</u>						<u>18th Kings highway</u>			<u>1-24-63</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)			
Removal		Jan 25, 1963		Woodlawn Cemetry			Edwardsville, Illinois						
24. FUNERAL DIRECTOR				ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
F. H. Weber				Edwardsville, Ill		JAN 25 1963		<u>Loan Smith, M.D.</u>					

Dr. O. P. J. Falk

Dr. Reis — Res. 7016 Kingsbury

#18 S. Kingshighway

F01-0150

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STATEMENT BY LICENSED EMBALMER

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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 Philip J. Weber

Licensed Embalmer No. 4989

P. O. Address Edwardsville, Ill.

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.

Michigan State Board of Health, Lansing, Michigan

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