

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004476

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 243

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED FEB 13 1963</b>	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> Length of stay in 1b <u>2 mos</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda Dilworth Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>Clayton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>8125 Roxburgh Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> First Middle Last <u>MATHILDA HALBERT</u>	
<b>4. DATE OF DEATH</b> Month Day Year <u>Jan. 21, 1963</u>	
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>
<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9/15/1870</u>
<b>9. AGE</b> (last birthday) <u>92</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>
<b>11. BIRTHPLACE</b> (City and state or country) <u>Jefferson County, Mo.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
<b>13a. FATHER'S NAME</b> <u>unk. Schaare</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Sophie unk</u>
<b>14. NAME OF HUSBAND OR WIFE</b> <u>William T. Halbert</u>	<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)
<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> Address <u>Mr. Walter A. Beck, 341 So. New Ballas Rd</u>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the rt kidney</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <u>Nov. 13 1962</u> <u>Jan 21 1963</u> and last saw her <u>Jan 20 1963</u> alive on _____ Death occurred at <u>6:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
<b>22a. SIGNATURE</b> (Degree or title) <u>Oliver DeBaugh M.D.</u>	<b>22b. ADDRESS</b> <u>Webster Groves Mo</u>
<b>22c. DATE SIGNED</b> <u>1/22/63</u>	(State)
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>	<b>23b. DATE</b> <u>1/24/63</u>
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New St. Marcus Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) <u>St. Louis County, Missouri</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>1-23-63</u>
<b>26. REGISTRAR'S SIGNATURE</b> <u>John B. Murphy M.D.</u>	

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DATE AMENDED  
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SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Dr. O. D. Seabough

105 W. Lockwood

MO 1-5002

3-5 pm

**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



Licensed Embalmer No. 4520

P. O. Address Albany 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.