

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008409
2690 STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB
AMENDED

VS 300 Rev. 4/59
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 2 **2229**
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 4 **1**
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.#.I		Inside Limits. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 1250 Chouteau Ave.		Reside on Farm (if outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BEULAH Middle EYERS Last			4. DATE OF DEATH Month 3 Day 2 Year 63
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (last birthday) 67
11. BIRTHPLACE (City and state or country) Louisville, Ky.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME James Buck		13b. MOTHER'S MAIDEN NAME Francis Wofford	
14. NAME OF HUSBAND OR WIFE Clarence		17. INFORMANT Address Mrs. Alma Armbruster, Horine, Mo.	
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. _____	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Coronary Thrombosis DUE TO (c) 4200 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 2-21-63 to 3-2-63 and last saw her/him alive on 3-2-63 Death occurred at 9:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Thomas J. Red</i> (Degree or title) M.D.		22b. ADDRESS 1515 LAFETTE AVE	
22c. DATE SIGNED 3-2-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/7/63	23c. NAME OF CEMETERY OR CREMATORY Rolla Cemetery	
23d. LOCATION (City, town, or county) (State) Rolla, Mo.			
24. FUNERAL DIRECTOR Null & Son Funeral Home, Rolla, Mo.		25. DATE RECD. BY LOCAL REG. MAR 7 1963	
		26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

MAR 19 1963

MAR 20 1963

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 Flawery Kahl

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.