

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2111 - 63-008614
STATE FILE NUMBER

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

FILED FEB 28 1963

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u> | | c. CITY OR TOWN <u>ST LOUIS</u> | |
| Length of stay in 1b. <u>10 DAYS</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>Edgewater Nursing Home</u> | | d. STREET ADDRESS (If outside, give location) <u>3858 Shenendoah</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|---------------------------|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>TESSIE FORTNER</u> | | | 4. DATE OF DEATH Month Day Year <u>2 23 63</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/4/95</u> | 9. AGE (last birthday) <u>67</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>SAMUEL WOOTEN</u> | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>CLARENCE FORTNER</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT <u>CLARENCE FORTNER 3858 SHENENDOAH</u> | | 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH | |

IMMEDIATE CAUSE (a) Arteriosclerosis of Arteries - Myocardial

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) ASHD 15612

DUE TO (c) HCV D.

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.
 Yes No 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 checked="" 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>11/26 62</u> to <u>2/23/63</u> and last saw her alive on <u>2/17/63</u> Death occurred at <u>10:30 p.m.</u> 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>40755 Grand</u> | |
| 22c. DATE SIGNED <u>2/25/63</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | |
| 23b. DATE <u>2/26/63</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cem.</u> | |
| 23d. LOCATION (City, town, or county) <u>ST LOUIS</u> | | 23e. STATE <u>Mo</u> | |
| 24. FUNERAL DIRECTOR <u>Thos. Kutis 2906 Francis</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>FEB 25 1963</u> | |
| 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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FORM NO. 10-1974

Dr. S. Kennedy
4075 Grand
DL 2-1370

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 J.A. Humphrey

Licensed Embalmer No. 4772

P. O. Address 506 Grand's

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.