

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009523

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1796**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 28 1963

VS 300  
Rev. 4/59

1

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

**76**

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 weeks</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>718 Lafayette Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Treadway</b>			4. DATE OF DEATH Month Day Year <b>2-18-63</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-82</b>
9. AGE (last birthday) <b>80</b>		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) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>William Treadway</b>	
14. MOTHER'S MAIDEN NAME <b>unk.</b>		15. NAME OF HUSBAND OR WIFE <b>Margarete (Dec)</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT Address <b>Charles Treadway, Jr, 718 Lafayette</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>420.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I, (a) <b>Pulmonary Edema - HCVU - ANEMIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>36 HOURS</b> <b>15 YEARS</b>
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 <b>1-10-63</b> to <b>2-18-63</b> and last saw her/him alive on <b>2-18-63</b> . Death occurred at <b>7:00 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Designee or title) <b>John J. Keenan, M.D.</b>		22b. ADDRESS <b>5800 Arsenal Ave</b>	
22c. DATE SIGNED <b>2-18-63</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>2/20-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>	
23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		23e. STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>McLaughlin, 2301 Lafayette,</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 19 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>			

2681 111 073 0121011

**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 \_\_\_\_\_

*James R. Chapman*

Licensed Embalmer No. \_\_\_\_\_

1550

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.