

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021458

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5151**

FILED MAY 17 1963

VS 300
Rev. 4/59

1
2 *4003*
3
4 *1*
5 *1*
6
7 *0*
8 *2*
9
10
11
12 *63-0*
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			c. CITY OR TOWN Overland		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			c. CITY OR TOWN Overland		
Length of stay in 1b 10 Days			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word Hosp.			d. STREET ADDRESS (If outside, give location) 9208 Arline		
Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last Rose A. Cripps			Month Day Year May 13, 1963		
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 3/7/1897	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE James O. Cripps		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. No	
17. INFORMANT James O. Cripps		Address 9208 Arline			
18. CAUSE OF DEATH (Enter only one cause per item) PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) vascular sclerotic myocarditis					several years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Diabetes Mellitus					several years
DUE TO (c) 260x					
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 May 2-1963 to May 13-1963 and last saw her alive on May 12-1963 Death occurred at 2:30 a.m. on the date stated above, and to the best of my knowledge from the causes stated.					
22a. SIGNATURE <i>Edward D. Snyder M.D.</i>			22b. ADDRESS 705 Olive St.		22c. DATE SIGNED 5-13-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/15/1963	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION (City, town, or county) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Collier Mortuary			25. DATE RECD. BY LOCAL REG. MAY 13 1963		26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>
ADDRESS St. Ann, Mo.					

USE BLACK INK OR TYPEWRITER RIBBON

63

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann 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.