

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021515

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2855**

STATE FILE NUMBER

FILED MAY 17 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

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: Missouri , 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 Enroute City Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Y. Last Duisen		4. DATE OF DEATH Month March Day 10 , Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/8/1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seams Dress		10b. KIND OF BUSINESS OR INDUSTRY Clothing Co.	11. BIRTHPLACE (City and state or country) Evansville, Indiana.
13a. FATHER'S NAME Robert Young		13b. MOTHER'S MAIDEN NAME Caroline (Unknown)	14. NAME OF HUSBAND OR WIFE Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of, etc.) No.		17. INFORMANT Roger Lemaire, 275 Derhake, Florissant, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Poisoning - sodium fluoride DUE TO (b) self ingested in home on or about DUE TO (c) March 10, 1963. Suicide PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 971.7			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) (See above)	
20c. TIME OF INJURY Hour 3-10-63 a.m. p.m.		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.) Home		20f. CITY, TOWN, OR LOCATION St Louis	
20g. COUNTY Mo.		STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 5:05 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L. Taylor, Coroner		22b. ADDRESS 1300 Clark Ave.	
22c. DATE SIGNED 3-11-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-11-63	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Dongola, Illinois.	
24. FUNERAL DIRECTOR DeBile Funeral Home, Portageville, Mo.		25. DATE RECD. BY LOCAL REG. MAR 11 1963	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

91

210-130-00

SEPS

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. M. Ambler

Licensed Embalmer No. 3643

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.