

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-022540

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 1610

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 27 1963

VS 300  
Rev. 4/59

1 400X

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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

9 AM

Barbara

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland</u>		Length of stay in 1b <u>1 mo</u>	c. CITY OR TOWN <u>Overland</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>Good Shepherd Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10441 Eaglewood</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUBY I DEMAS</u>			4. DATE OF DEATH Month Day Year <u>May 16 1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE (last birthday) <u>65</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11a. FATHER'S NAME <u>John McDowell</u>		11b. BIRTHPLACE (City and state or country) <u>Fredricktown Mo</u>	
13a. FATHER'S NAME <u>John McDowell</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Underwood</u>	
14. NAME OF HUSBAND OR WIFE <u>William (deceased)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT Address <u>Robert Williams Overland Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Failure + Cerebral Anoxia</u> DUE TO (b) <u>Malnutrition + Cachexia</u> DUE TO (c) <u>Metastatic Carcinomatosis</u> 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 <u>3/18/63</u> to <u>5-14-63</u> and last saw her/him alive on <u>5-15-63</u> Death occurred at <u>5-15-63 3:40 P</u> m 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>2335 Brown Rd</u>	
22c. DATE SIGNED <u>5-17-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>5/18/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anaconda Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St Clair Co Mo</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Ortmann F Home</u>		25. DATE RECD. BY LOCAL REG. <u>5-18-63</u>	
26. ADDRESS <u>9222 Lackland Overland Mo</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE BLACK INK OR TYPEWRITER RIBBON

(022 1111)

**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 Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address \_\_\_\_\_

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.