

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026488

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6839**

STATE FILE NUMBER

FILED JUL 5 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis		a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5798 Pershing		d. STREET ADDRESS (If outside, give location) 5798 Pershing	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
Rose Volland			June 28, 1963		
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-31-81	9. AGE (last birthday) 82	IF UNDER 1 YEAR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME John F. Meyer		13b. MOTHER'S MAIDEN NAME Anna Fechtel		14. NAME OF HUSBAND OR WIFE Otto F. Volland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No			16. SOCIAL SECURITY NO. 		
			17. INFORMANT Address Otto F. Volland, 5798 Pershing		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Coronary Disease, Cardiac Arrest		5 yrs
DUE TO (b) Atherosclerosis, Gen. arteriosclerosis		20 yrs
DUE TO (c) 4201		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Coronary Artery (Angina Pectoris)		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
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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 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 **April 1944** to **6-28-63** and last saw her ^{her} alive on **6/17/63**
 Death occurred at **2:45 PM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Daniel P. Dexter M.D.		22b. ADDRESS 634 N. Grand Ave		22c. DATE SIGNED 6/29/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE JUL 1 - 1963	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) St. Louis Mo.	
24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell		25. DATE RECD. BY LOCAL REG. JUL 1 1963	26. REGISTRAR'S SIGNATURE Loard Smith. M.D.	

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
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 2 **20**
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 4 **1**
 5 **1**
 6
 7 **0**
 8 **2**
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 12 **90-0**
 13
90
 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

ARIZONA STATE

1940

8:01

EDF

Mr Alan Sauter
mes Phoenix 1940
024
02

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 *[Signature]*

Licensed Embalmer No. 46799

P. O. Address 3840 Lendell

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.