

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030817

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 2219

STATE FILE NUMBER

FILED JUL 22 1963

VS 300
Rev. 4/59
1400X
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland		c. CITY OR TOWN St. Ann	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lackland Nursing Home		d. STREET ADDRESS 10820 Cavan	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) BERTHA MANGRUM		4. DATE OF DEATH 7 9 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-30-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CHESTER ILL.
13a. FATHER'S NAME EMMERSON GRAY		14. NAME OF HUSBAND OR WIFE OLIVER M. MANGRUM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		17. INFORMANT MRS. MILDRED OSTRANDER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kidney failure. DUE TO (b) Congestive Heart failure - Arteriosclerosis. DUE TO (c) fracture of Hip - Senile.		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)	
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 1-24-58 to 7-11-63 and last saw her alive on 7-11-63 . Death occurred at 5:07 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE L.P. Williams		22b. ADDRESS 10426 Lackland	
22c. DATE SIGNED 7-2-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7-12-63	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) Signal Hill, Illinois	
24. FUNERAL DIRECTOR KREIGSHAUSER MORTUARIES - WEST		25. DATE RECD. BY LOCAL REG. 7-12-63	
26. REGISTRAR'S SIGNATURE John B. Murphy			

D. Williams
10426 LACKLAND
[GAM. FR.]

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 *William D White*

Licensed Embalmer No. 4291

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.