

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034679

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2603

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 4 1963			
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>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b	c. CITY OR TOWN <u>Fenton,</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Van Meter</u> Last <u>Van Meter</u>			4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1918</u>
9. AGE (last birthday) <u>45</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Diversified Metals</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bonne Terre, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Roy Coffman</u>		13b. MOTHER'S MAIDEN NAME <u>Irene Coffman</u>	14. NAME OF HUSBAND OR WIFE <u>Darnell Van Meter</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Viola Wigger, Sister</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>Multiple traumatic injuries</u> DUE TO (b) <u> </u> DUE TO (c) <u> </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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>1 car accident (driver)</u>	
20c. TIME OF INJURY Hour <u>9:49</u> p.m. <u>3:20</u> Month, Day, Year <u>8/17/63</u>			
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.) <u>highway</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Louis Missouri</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>DOA Co. Hosp. 10:16 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Raymond H. Haid</u> Coroner Clayton, Missouri		22b. ADDRESS	22c. DATE SIGNED <u>8/21/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8/21/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Mem. Park</u>	23d. LOCATION (City, town, or county) (State) <u>Bonne Terre, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Dale Sparks Bonne Terre, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/18/63</u>	26. REGISTRAR'S SIGNATURE <u>John W. Wiggler</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR TYPEWRITER RIBBON

VS 300
Rev. 4/59

1 4002

2 0500

3

4 1

5 1

6

7 0

8 2

9 X

10

11 400

12 45-3

13

SEP 18 1963

FEB 7 1964

SEP 5 - 1968

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

Everett Sparks

Licensed Embalmer No. 4287

P.O. Address Donnellville 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.

1000
1000
1000
1000
1000
1000