

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-041828**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10335

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 24 1963

VS 300	DATE AMENDED
Rev. 4/59	
1	
2 <u>222</u>	
3 <u>2</u>	
4 <u>1</u>	
5 <u>2</u>	
6	
7 <u>9</u>	
8 <u>1</u>	
9	
10	
11	
12 <u>75-1</u>	
13	

USE BLACK INK OR TYPEWRITER RIBBON

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		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Length of stay in 1b <u>Life</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY		c. CITY OR TOWN <u>St. Louis</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>ST. LOUIS CITY HOSP. #1</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>707 S. Broadway</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZ (Elizabeth) MOEHLMANN</u>				4. DATE OF DEATH Month Day Year <u>10 14 63</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>1/13/94</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR		
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>Home</u>		11. BIRTHPLACE (City and state or country) <u>Unknown 9</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Fred (Deceased)</u>				Address <u>St. Louis, Mo.</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 <u>Ethel Williams, 707 S. Broadway</u>					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration pneumonia</u> DUE TO (b) <u>chronic pyelonephritis</u> DUE TO (c) <u>6000</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						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 checked="" type="checkbox"/> NO <input 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>10/10/63</u> to <u>10/14/63</u> and last saw her/him alive on <u>10/14/63</u> Death occurred at <u>2:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Martin P. Blin MD</u>			22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		22c. DATE SIGNED <u>10/14/63</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-17-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>				
24. FUNERAL DIRECTOR <u>McLaughlin, 2301 Lafayette,</u> <u>St. Louis, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>OCT 17 1963</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>				

(Licensed Embalmer's Statement on Reverse Side)

PS 2130-74

FORM

1000

ST. LOUIS, MO.

ST. LOUIS CITY HOSPITAL

TO THE BOARD OF HEALTH

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

*James R. Chapman*

Licensed Embalmer No.

4550

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.

TO/MI/OI

TO/MI/OI

TO/MI/OI

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