

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041418

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10917**

FILED NOV 15 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 10 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		c. CITY OR TOWN Ellisville		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 146 Clarkson Road		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First Monte Middle C. Last Etherton			4. DATE OF DEATH Month Nov. Day 3 Year 1963						
5. SEX M		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 4-5-1887		9. AGE (last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M.D.		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (City and state or country) Murphesboro, Ill.		12. CITIZEN OF WHAT COUNTRY USA						
13a. FATHER'S NAME Frankk Etherton			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Dorothy						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Dorothy Etherton		Address 146 Clarkson Rd. Ellisville, Mo.						
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) Emphysema of the Left Bladder with self-administered oxygen												
Conditions, if any, which gave rise to above cause (a), stating the underlying cause" last.												
DUE TO (b) 585x												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis of Right Coronary Artery										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		
7th Army. Atherosclerosis Heart Disease												
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 10/23/63 to 11/3/63 and last saw him alive on 11/2/63 Death occurred at 8:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.												
22. SIGNATURE Robert R. Ramsey (Degree or title) M.D.						22b. ADDRESS 119 Church St. Ferguson 35, Mo			22c. DATE SIGNED 11/4/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-5-63		23c. NAME OF CEMETERY OR CREMATORY Sunset		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.						
24. FUNERAL DIRECTOR Schrader Funeral Home ADDRESS 500 Manchester Rd. Ballwin, Mo.				25. DATE RECD. BY LOCAL REG. NOV 4 1963		26. REGISTRAR'S SIGNATURE Roan Smith, M.D.						

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
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 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 USE BLACK INK OR TYPEWRITER RIBBON

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 Richard Bopp

Licensed Embalmer No. 4584

P. O. Address Ballwin 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.

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