

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0016211

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 170

MY FILED 05 64

VS 300  
Rev. 4/59

1 0941  
2 0940  
3  
4 1  
5 1  
6  
7 0  
8 2  
9 1/969  
10  
11  
12 1-0  
13 1-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Bonne Terre</b>		Length of stay in 1b <b>1-Week</b>	c. CITY OR TOWN <b>Desloge</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>506 - Monroe St</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Maggie</b> Middle <b>Andrews</b> Last <b>Saffell</b>			4. DATE OF DEATH Month <b>April</b> Day <b>27th.</b> Year <b>1964</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1895 - 68</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Bonne Terre, Rt. 1 - Mo.</b>
13a. FATHER'S NAME <b>McNally A Patterson</b>		13b. MOTHER'S MAIDEN NAME <b>Alice Louise Covington</b>	12. CITIZEN OF WHAT COUNTRY <b>USA.</b>
14. NAME OF HUSBAND OR WIFE <b>John Henry Saffell</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>- -</b>		17. INFORMANT Address <b>John H. Saffell, Desloge, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Osteosarcoma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>approx 9 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 a.m. _____ p.m. _____ Month, Day, Year _____			
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from <b>Oct 1963</b> to <b>April 27, 1964</b> and last saw her alive on <b>April 27, 1964</b> . Death occurred at <b>6:30P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. I. Foster MD</b> (Degree or title)		22b. ADDRESS <b>Desloge, Mo</b>	22c. DATE SIGNED <b>4-28-64</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/30/1964</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Marvin Chapel Cemetery St. Francois Co. Missouri</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <b>C.Z. Boyer &amp; Son Desloge, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Apr. 28, 1964</b>	26. REGISTRAR'S SIGNATURE <b>Esther Rudloff</b>

USE BLACK INK OR TYPEWRITER RIBBON

MAY 6 1964

**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 B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Desloge, 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.