

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0011965 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

APR 14 64 316

Primary Registration District No.

Registrar's No.

VS 300
Rev. 4/59

10940
20940
3
4 0
5 1
6
7 0
8 2
334A
10
11
12 93-0
13 1-0

DATE AMENDED

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 St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 15 days		c. CITY OR TOWN Desloge		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 506 N. Grant		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Alfred Roux			4. DATE OF DEATH Month April Day 4 Year 1964										
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-10-1876		9. AGE (last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming				11. BIRTHPLACE (City and state or country) Ste. Genevieve Co., Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Henry Roux				13b. MOTHER'S MAIDEN NAME Laura Whitt				14. NAME OF HUSBAND OR WIFE Amanda Belle Dace					
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. Unknown		17. INFORMANT Records, State Hospital # 4, Farmington, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Inanition - - - - - Int. 4 days.													
DUE TO (b) Psychosis - - - - - intermittently for Int. 5 yrs.													
DUE TO (c) Cerebral arteriosclerosis - - - - - Int. 10 yrs.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Pulmonary tuberculosis, bilateral, and psychosis.													
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 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		0									
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 March 20, 1964 to April 4, 1964 and last saw him alive on April 4, 1964 Death occurred at 3 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>John A. Brennan M.D.</i>				22b. ADDRESS State Hospital No. 4 Farmington, Missouri				22c. DATE SIGNED 4-4-64					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-6-64		23c. NAME OF CEMETERY OR CREMATORY Bonne Terre Cemetery				23d. LOCATION (City, town, or county) (State) Bonne Terre, Missouri					
24. FUNERAL DIRECTOR Sparks Funeral Home, Flat River, Missouri				ADDRESS		25. DATE RECD. BY LOCAL REG. April 4, 1964		26. REGISTRAR'S SIGNATURE <i>Cather Rudloff</i>					

USE BLACK INK OR TYPEWRITER RIBBON

030113

1951

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 Murphy L. Spohn

Licensed Embalmer No. 4236

P. O. Address 1st Ave. 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.