

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012453

FILED VS MAR 25 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3020** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri				Length of stay in 1b		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Maternity				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5457 Vernon	
3. NAME OF DECEASED (Type or print) First Middle Last Coburn				4. DATE OF DEATH Month Day Year March 13 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/13/60	
9. AGE (last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hrs Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY United States	
13a. FATHER'S NAME John William Coburn				13b. MOTHER'S MAIDEN NAME Shirley Ann Thomas		14. NAME OF HUSBAND OR WIFE None	
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 Address John & Shirley Coburn 5457 Vernon	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURE PREMATUREITY DUE TO (b) INTRACRANIAL BLEEDING SUSPECTED DUE TO (c) ATELECTASIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 760.5						INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
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.) 760.5			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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 13, 1960 to Mar. 13, 1960 and last saw ^{xx} him alive on March 13, 1960 Death occurred at 5:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>[Signature]</i>				22b. ADDRESS St. Louis Maternity Hosp		22c. DATE SIGNED 3-14-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-15-1960		23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo	
24. FUNERAL DIRECTOR ADDRESS JAS H. RANDLE & SON 3133 Bell Ave				25. DATE RECD. BY LOCAL REG. MAR 15 1960		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James H Randle
Not Embalmed
Licensed Embalmer No. _____

P. O. Address _____

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.