

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028434

FILED VS. JUL 22 1960

318 Primary Registration District No. 1003 Registrar's No. 6699

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Saint Louis</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>D.O.A. Homer G. Phillips</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4893 Kossuth</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>CLAUDE</b> Middle <b>D.</b> Last <b>HOLLAND</b>				4. DATE OF DEATH Month <b>6</b> Day <b>30</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</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>10/15/89</b>		9. AGE (last birthday) <b>70</b>		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) <b>Retired Postal Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Thomas Holland</b>				13b. MOTHER'S MAIDEN NAME <b>Narcisa</b>				14. NAME OF HUSBAND OR WIFE <b>Florence Holland</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>Florence Holland 4893 Kossuth</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>Coronary thrombosis</b>								INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>4201</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 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 <b>12:14 P.</b> to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>James B. Gates Deputy Coroner</b>						22b. ADDRESS <b>1300 Claiborne</b>			22c. DATE SIGNED <b>7-2-60</b>				
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7/6/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>							
24. FUNERAL DIRECTOR <b>Charles J. Gates 4107 Finney</b>				25. DATE RECD. BY LOCAL REG. <b>JUL 2 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>							

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 Gayton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to conform 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.