

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 24 1960**

**318**

Primary Registration District No. **1003**

Registrar's No.

**7972**

**-60-032352**  
STATE FILE NUMBER

NDEB

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>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. 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>Homer G. Phillips Hospi</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1703 Carver Lane</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clifford M. Hood</b>				4. DATE OF DEATH Month Day Year <b>8 - 8 - 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</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>7-3-1940</b>	9. AGE (last birthday) <b>20</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>1 5</b>		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Clifford Hood</b>			13b. MOTHER'S MAIDEN NAME <b>Vanilla Daniels</b>			14. NAME OF HUSBAND OR WIFE <b>Rachel Hood</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>Mrs. Vanilla Smith 2310 Cass Apt. 202</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>Massive Intra Cranial Hemorrhage</b> DUE TO (b) <b>Gunshot wound of the skull over Brain</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Suffered in room at 2310 Cass Ave</b>						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 checked="" 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 at item 18) <b>Open Verdict about 1000 a.m., Aug. 8th 1960</b>					
20c. TIME OF INJURY Hour a.m. Month, Day, Year <b>1000 a.m. 8 8 60</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>Room - Home</b>					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>St Louis</b>		COUNTY <b>Mo</b>		STATE <b>919.0 19</b>	
21. I attended the deceased from <b>4:15 P.</b> 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>Patrick Taylor Cosore</b>				22b. ADDRESS <b>1300 Clark Avenue</b>		22c. DATE SIGNED <b>8-12-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8-13-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Father Dixon Cemet.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Ellis Funeral Home 2820 Stoddard St.</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 12 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

*Guilford E. Bell*

Licensed Embalmer No. *14190*

P. O. Address *St. Louis*

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.