

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) <b>St. Louis</b>				Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer B Phillips</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside give location) <b>2808<sup>th</sup> No. Sarah</b>	
3. NAME OF DECEASED (Type or print) <b>Rickie</b>				First		Middle	
4. DATE OF DEATH <b>10 18 60</b>				Month		Day Year	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>Col.</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 6-60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS - MO</b>	
13a. FATHER'S NAME <b>DOUGLAS MOORE</b>				13b. MOTHER'S MAIDEN NAME <b>SHIRLEY A CAFF</b>		14. NAME OF HUSBAND OR WIFE <b>None</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>None</b>		17. INFORMANT <b>Shirley Moore 2808 No. Sarah</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>Toxic Diarrhea</b> DUE TO (b) DUE TO (c) <b>571.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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)						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 _____ to _____ her and last saw him alive on _____ Death occurred at <b>7:18</b> <b>4.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Patrick E. Taylor, Coroner</b>				22b. ADDRESS <b>1300 Clark Ave.</b>		22c. DATE SIGNED <b>10/21/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-22-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery, St. Louis Co., Mo.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>Richardson F. Home 2625 Glasgow</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 21 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed AD Richards

Licensed Embalmer No. 292

P. O. Address Ct

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