

AMENDED  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **584**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Missouri</b>                  |  | a. STATE <b>Missouri</b> COUNTY   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NQT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>St. Louis City Hosp. #1</b> |  | d. STREET ADDRESS<br><b>1302 R. South 8th St.</b>                                     | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>Frank</b> Middle Last <b>McCourtney</b> | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>16</b> Year <b>61</b> |
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|                       |                                  |   |                                     |                                     |                                |                              |
|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>Negro</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/4/1900</b> | 9. AGE (last birthday)<br><b>60</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b> | 11. BIRTHPLACE (City and state or country)<br><b>Festus, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |
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| 13a. FATHER'S NAME<br><b>Wm McCourtney</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Susie</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Mary McCourtney</b> |
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|   |   |  |                                      |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>Unknown</b> | 17. INFORMANT<br><b>Mr. Robert Nogan</b> | Address<br><b>1307 A. S. 8th St.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
| DUE TO (b) _____  |  |   |
| DUE TO (c) <b>491X</b>  |  |   |

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| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Cardiac failure</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED?<br>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.) |
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|   |                  |
|---|------------------|
| 20c. TIME OF INJURY<br>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 |
|--|--|---|

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| 21. I attended the deceased from <b>1-15-61 6:50p</b> to <b>1-16-61</b> and last saw her/him alive on <b>1-16-61</b><br>Death occurred at <b>8:30</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title)<br><b>W. Gates Trotter, M.D.</b> | 22b. ADDRESS<br><b>1515 Lafayette Ave.</b> | 22c. DATE SIGNED<br><b>1/16/61</b> |
|---|--|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>1/28/61</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Missouri</b> |
|---|-----------------------------|---|--|

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| 24. FUNERAL DIRECTOR<br><b>E. B. Keonce</b> | ADDRESS<br><b>1221 North Grand Blvd.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 19 1961</b> | 26. REGISTRAR'S SIGNATURE<br><b>Robert Smith, M.D.</b> |
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**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

*Melvin Blackburn*

Licensed Embalmer No. 5962

P. O. Address 1251 N Grand

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.