

# SOUTH DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318      1003      6047      -61-023102  
 Registration District No.      Primary Registration District No.      Registrar's No.      STATE FILE NUMBER

AMENDED

**FILED JUL 7 1961**

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b. <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3934 Olive St.</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First      Middle      Last <b>Ruth      Eliza      Rose</b>						4. DATE OF DEATH Month      Day      Year <b>6      28      61</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col.</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>I/10/97</b>		9. AGE (last birthday) <b>64</b>		IF UNDER 1 YEAR Months      Days <b>5      18</b>		IF UNDER 24 HR Hours      Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Creve Coeur Lake, Mo. USA.</b>				12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME <b>Mitchell Scott</b>				13b. MOTHER'S MAIDEN NAME <b>Eliza Brooks</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.		17. INFORMANT      Address <b>Archie Rose 3934 Olive St.</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>Cerebral Apoplexy</b>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (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 checked="" type="checkbox"/> Unknown			
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.)									
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 _____ 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 <b>Paul Johnson</b>				(Degree or Title) <b>Deputy Coroner</b>				22b. ADDRESS <b>1300 Clark</b>				22c. DATE SIGNED <b>6/29/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)				
<b>Burial</b>			<b>7/3/61</b>			<b>Washington Park Cemetery</b>			<b>St. Louis Co, Mo.</b>				
24. FUNERAL DIRECTOR      ADDRESS <b>Wright's Funeral Home 3100 Easton Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>JUN 29 1961</b>				26. REGISTRAR'S SIGNATURE <b>Dean Smith, M.D.</b>					

FILE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATE OF ILLINOIS

DEPARTMENT OF HEALTH

STATE OF ILLINOIS

Yes  No

Yes  No

Yes  No

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

Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Ave

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.