

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

7619

-61-030796

STATE FILE NUMBER

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

AMENDED

FILED AUG 28 1961

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Mo</i> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>St Louis</i>               |  | c. CITY OR TOWN <i>St Louis</i>   |  |
| Length of stay in lb   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <i>DOA C.T.Y #1</i> |  | d. STREET ADDRESS (If outside, give location)<br><i>2816 STODDARD</i>   |  |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>               |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |

|   |        |  |   |       |     |  |
|---|--------|--|---|-------|-----|--|
| 3. NAME OF DECEASED (Type or print)<br><i>Rebecca Hicks</i> |        |  | 4. DATE OF DEATH<br>Month <i>Aug</i> Day <i>14</i> Year <i>1961</i> |       |     |  |
| First   | Middle |  | Last  | Month | Day |  |

|                         |                                 |  |   |                                     |                           |                        |       |      |
|-------------------------|---------------------------------|--|---|-------------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX<br><i>Female</i> | 6. COLOR OR RACE<br><i>Repo</i> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>JUNE 11 1913</i> | 9. AGE (last birthday)<br><i>48</i> | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HR<br>Days | Hours | Min. |
|-------------------------|---------------------------------|--|---|-------------------------------------|---------------------------|------------------------|-------|------|

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><i>COLUMBUS, MISS.</i> | 12. CITIZEN OF WHAT COUNTRY<br><i>U.S.A.</i> |
|---|-----------------------------------|--|--|

|   |   |  |
|---|---|--|
| 13a. FATHER'S NAME<br><i>JOSEPH HUMPHRIES</i> | 13b. MOTHER'S MAIDEN NAME<br><i>AMIE WORTHLEY</i> | 14. NAME OF HUSBAND OR WIFE<br><i>JUNIOR</i> |
|---|---|--|

|   |  |   |
|---|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>NO</i> | 16. SOCIAL SECURITY NO.<br><i>none</i> | 17. INFORMANT Address<br><i>AMIE WORTHLEY / 2816 STODDARD</i> |
|---|--|---|

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |  | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <i>Coronary Occlusion,</i>  |  |   |
| DUE TO (b) <i>Coronary Sclerosis.</i>   |  |   |
| DUE TO (c) <i>4201</i>  |  |   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown |

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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 \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.

Death occurred at: \_\_\_\_\_ *1130 A* on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                   |                                    |
|--|-----------------------------------|------------------------------------|
| 22a. SIGNATURE<br><i>Paul Simon</i> (Deputy Coroner) | 22b. ADDRESS<br><i>1300 Clark</i> | 22c. DATE SIGNED<br><i>8/15/61</i> |
|--|-----------------------------------|------------------------------------|

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>REMOVAL</i> | 23b. DATE<br><i>8-21-61</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>NATIONAL</i> | 23d. LOCATION (City, town, or county) (State)<br><i>JEFFERSON BNS. MO</i> |
|---|-----------------------------|---|---|

|  |  |  |
|--|--|--|
| 24. FUNERAL DIRECTOR ADDRESS<br><i>RELIABLE FUNERAL SYSTEM</i> | 25. DATE RECD. BY LOCAL REG.<br><i>AUG 16 1961</i> | 26. REGISTRAR'S SIGNATURE<br><i>Paul Smith, M.D.</i> |
|--|--|--|

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

**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

*Clarence Brown*

Licensed Embalmer No. 4755

P. O. Address 1389 Union

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.