

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046376
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12307

AMENDED

FILED JAN 11 1962

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | Length of stay in 1b | c. CITY OR TOWN <u>St. Louis</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>5643 Julian</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Gold</u> Middle <u>Harold</u> Last | | | 4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>61</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-9-1891</u> |
| 9. AGE (last birthday) <u>70</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> | 11. BIRTHPLACE (City and state or country) <u>Tennessee</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Elijah Harold</u> | 13b. MOTHER'S MAIDEN NAME <u>Lucy Harris</u> |
| 14. NAME OF HUSBAND OR WIFE <u>Unknown</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. INFORMANT <u>Lawrence Harold</u> | | Address <u>5643 Julian</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suspected Pancreatic Carcinoma</u> DUE TO (b) _____ DUE TO (c) <u>157X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u> |
| 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 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 _____ 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 <u>12-12-61</u> to <u>12-26-61</u> and last saw ^{him} him alive on <u>12-26-61</u> Death occurred at <u>11:55</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Sydney A. Trane, M.D.</u> (Degree or title) | | 22b. ADDRESS <u>2601 N. Whittier Street</u> | 22c. DATE SIGNED <u>12-29-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>1 Jan 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Green</u> ADDRESS <u>1221 North Grand Blvd.</u> | | 25. DATE RECD. BY LOCAL REG. <u>DEC 29 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u> |

DATE AMENDED

INSTEAD OF

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed MA J. B. Williams

Licensed Embalmer No. 36117

P. O. Address 1721 N. 1st St.

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.