OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=61-047783

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12477 STATE FILE NUMBER

FILED JAN 19 1962

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4204 E. Cote Brilliante
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First | Middle | Last: Cage #2
4. DATE OF DEATH Month Day Year: 12-30-61
5. SEX: Fem.
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12-29-61
9. AGE (last birthday) IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HR: Hours 8, Min. 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Saint Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME: Lucinda Ruth Cage
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary D. Jett, R.R.L., 2601 N. Whittier Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Aspiration Syndrome
DUE TO (c): Immaturity 762.5
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 12-29-61, to 12-30-61 and last saw ~~it~~ him alive on 12-30-61
Death occurred at 5:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature], M. D.
22b. ADDRESS: 2601 N. Whittier
22c. DATE SIGNED: 1-4-62

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: JAN 31 1962
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Rowland Mortuary Svc.
ADDRESS: 4104-06 Manchester 4104-06 Manchester
25. DATE RECD. BY LOCAL REG.: JAN 11 1962
26. REGISTRAR'S SIGNATURE: [signature] M.D.

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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