

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003793

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 145

STATE FILE NUMBER

FILED JAN 11 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		c. CITY OR TOWN <u>St. Louis</u>				
Length of stay in 1b		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>ST. LOUIS CITY HOSP. #1.</u>		d. STREET ADDRESS (If outside, give location) <u>4534 Gibson</u>				
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>GEORGE</u> Middle Last			4. DATE OF DEATH Month <u>JAN</u> Day <u>3</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-15</u>	9. AGE (last birthday) <u>46</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armor Meats</u>		11. BIRTHPLACE (City and state or country) <u>E. St. Louis, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Grover C. George</u>		13b. MOTHER'S MAIDEN NAME <u>Cora Kirby</u>		14. NAME OF HUSBAND OR WIFE <u>Geneva George</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Geneva George 4560 Clarence</u>		
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>MEGACYSTITIS</u>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
DUE TO (b) <u>PERFORATED ESOPHAGUS</u>						
DUE TO (c) <u>VOMITING 527.2</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 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.)		
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>1/1/62</u> to <u>JAN, 3, 1962</u> and last saw her/him alive on <u>JAN. 3, 1962</u> Death occurred at <u>8:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>J. E. Smith M.D.</u> (Degree or title)			22b. ADDRESS <u>1515 LAFAYETTE AVE</u>		22c. DATE SIGNED <u>1/3/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-5-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>	
24. FUNERAL DIRECTOR <u>McLaughlin 2301 Lafayette Ave</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>JAN 5 1962</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>	

DATE AMENDED
9-2
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
ITEM NO.

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

A. G. Farris

Licensed Embalmer No.

3384

P. O. Address

St. Louis

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.