

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-004261

AMENDED

Registration Certificate No. **2318**

Primary Registration District No. **1003**

Registrar's No. **1382**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO.		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS, MO		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP #1			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1104 S. COMPTON		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First JULIA Middle (MOTLEY) Last MOTLEY				4. DATE OF DEATH Month 1 Day 8 Year 62															
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/28/03		9. AGE (last birthday) 58		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) UNKNOWN				10b. KIND OF BUSINESS OR INDUSTRY ???		11. BIRTHPLACE (City and state or country) MISSISSIPPI			12. CITIZEN OF WHAT COUNTRY U.S.A										
13a. FATHER'S NAME GEORGE				13b. MOTHER'S MAIDEN NAME LUCINDA HARISTON				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. NO		17. INFORMANT Address ST. LOUIS CITY HOSPITAL #1.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 157X DUE TO (c)										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. <input type="checkbox"/> Yes <input checked="" 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 1-6-62 to 1-8-62 and last saw her/him alive on 1-8-62 Death occurred at 11:50 pm on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE John Mc Donough MD (Degree or title)						22b. ADDRESS 1515 LAFAYETTE AVE.				22c. DATE SIGNED 1-8-62									
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 Akor Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.				25. DATE RECD. BY LOCAL REG. JAN 31 1962				26. REGISTRAR'S SIGNATURE Carl Smith, M.D.											

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.