

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008353

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **2410** STATE FILE NUMBER

FILED MAR 15 1962 318

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MEDICAL CERTIFICATION

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| | | | | | | | | | | | | | | | |
|--|--|--|-------|---|--|---|--|--|------|---|--|---|--|------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in lb | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | | c. CITY OR TOWN | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| a. COUNTY | | St. Louis, Missouri | | | | Illinois | | St. Clair | | East St. Louis | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | | | | | | | | |
| St. Mary's Infirmary | | | | | | 1906 1/2 Market Street | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First | | | Middle | | | Last | | | 4. DATE OF DEATH Month Day Year | | | |
| EMMA | | | KYE | | | February 28, 1962 | | | | | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HR | | | |
| Female | | Negro | | | | 4/13/02 | | 59 | | Months Days Hours Min. | | | | | |
| 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) | | | | 12. CITIZEN OF WHAT COUNTRY | | | |
| Housewife | | | | None | | | | Prairie Point, Miss. | | | | U.S.A. | | | |
| 13a. FATHER'S NAME | | | | 13b. MOTHER'S MAIDEN NAME | | | | 14. NAME OF HUSBAND OR WIFE | | | | | | | |
| SHEDRICK KYE | | | | MORTAH HAND | | | | None | | | | | | | |
| 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 Address | | | | | | | |
| No | | | | None | | | | Bernice Jackson | | | | 1906 1/2 Market East St. Louis, Ill. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | 1 wk | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | | | UnKnown | | | |
| DUE TO (b) | | | | | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | | | | | |
| 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 | | | | | |
| | | | | | | | | | | +201 | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT | | SUICIDE | | HOMICIDE | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | | | | |
| | | | | | | | | 4201 | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | 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 _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) | | | | | | | | | | | | 22b. ADDRESS | | 22c. DATE SIGNED | |
| [Signature] | | | | | | | | | | | | 1401 Coth | | 3/1/62 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town, or county) (State) | | | | | | | |
| Removal | | 3/2/1962 | | Local | | | | Columbus, Mississippi | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Marion Office 2111 Missouri Avenue East St. Louis, Illinois | | | | MAR 1 1962 | | Earl Smith, M.D. | | | | | | | | | |

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 Frank Prokopi

Licensed Embalmer No. 4356

P. O. Address St. Louis, Mo

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.