

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008455

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2128

FILED FEB 28 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>20 YRS.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		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>2643 Lucas</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Miles</u> Last <u>Miles</u>			4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>62</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>4-2-1897</u>		9. AGE (last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>62</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state of country) <u>LeFlow miss</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>BRANDT miles</u>			13b. MOTHER'S MAIDEN NAME <u>MEG COMAR</u>			14. NAME OF HUSBAND OR WIFE <u>LUCK COHEN</u>			Address <u>2643 LUCAS</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. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>LUCK COHEN</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u>6000</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 <u>8:50</u> Month, Day, Year <u>1-30-62</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1-30-62</u>		20f. CITY, TOWN, OR LOCATION <u>2-19-62</u>		COUNTY <u>Berkley 22</u>		STATE <u>MO</u>		
21. I attended the deceased from <u>1-30-62</u> to <u>2-19-62</u> and last saw <sup>her</sup> him alive on <u>2-19-62</u> Death occurred at <u>8:50</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Sydney L. Mason MD</u> (Degree or title)		22b. ADDRESS <u>2601 N. Whittier Street</u>		22c. DATE SIGNED <u>2-20-62</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2-26-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON PARK</u>		23d. LOCATION (City, town, or county) <u>Berkley 22</u>		23e. (State) <u>MO</u>				
24. FUNERAL DIRECTOR <u>PRICE UND, CO.</u>		ADDRESS <u>2829 WASHINGTON</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 21 1962</u>		26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>						

**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 Edward W. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Fenway Ave

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.