

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008830

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1543**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 16 1962

VS 300  
Rev. 4/59

1

2 **22**

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2429 Biddle #501</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Warren</b> Middle <b>Reginald</b> Last <b>Taylor</b>						4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>62</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>May 30, 61</b>		9. AGE (last birthday) <b>0</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b>		IF UNDER 24 HR Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>Hubert Johnson</b>				13b. MOTHER'S MAIDEN NAME <b>Edith Taylor</b>				14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edith Taylor</b>		Address <b>2429 Biddle St. Apt. 501</b>			
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) <b>Respiratory Failure</b>										<b>Undet.</b>	
DUE TO (b) <b>Membraneous Laryngo-tracheo Bronchitis</b>										<b>Undet.</b>	
DUE TO (c) <b>500X</b>											
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 <b>4:45</b> 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 <b>1-27-62</b> to <b>1-31-62</b> and last saw him alive on <b>1-31-62</b>		Death occurred at <b>4:45</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Paul W. Kelly, M.D.</i> (Degree or title)				22b. ADDRESS <b>2601 N. Whittier Street</b>				22c. DATE SIGNED <b>2-2-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-6-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>					
24. FUNERAL DIRECTOR <b>Ellis Funeral Home, Inc.</b> ADDRESS <b>2820 Stoddard</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 5 1962</b>		26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>					

USE BLACK INK OR TYPEWRITER RIBBON

**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 Fulton E. Culkin

Licensed Embalmer No. 498

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.