

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED FEB 28 1962

2064-62-008927  
 STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
 Rev. 4/59

1  
 2 8120  
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 4 3  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 <b>20 minutes</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>		c. CITY OR TOWN <b>Madison</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Infirmary</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>300 3rd Street</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CARRIE</b>			First	Middle	Last <b>WHITE</b>	4. DATE OF DEATH <b>Feb 16, 1962</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 1, 1901</b>		9. AGE (last birthday) <b>60</b>	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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Fordice, Ark.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Millard Lee</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>A. H. White</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>A.H.White-300 3rd St., Madison, Ill.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>hypertension</b> <b>hypertension</b> DUE TO (b) <b>420-1</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4yr</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 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 <b>Jan 1 62</b> and last saw her <b>Feb 16 62</b> Death occurred at <b>4 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				and last saw him alive on <b>Feb 16 62</b>				
22a. SIGNATURE <b>Walter A. Young</b> (Degree or title)			22b. ADDRESS <b>4635 Eastern St. Mo. Mo.</b>		22c. DATE SIGNED <b>2/19/62</b>			
23a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>		23b. DATE <b>2/21/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National</b>		23d. LOCATION (City, town, or county) <b>Jefferson Barracks, Mo.</b> (State)		
24. FUNERAL DIRECTOR <b>Marshall's Funeral Home</b> ADDRESS <b>E. St. Louis, Ill.</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 20 1962</b>		26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>		

**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

*Thomas M. Hobson*

Licensed Embalmer No. 4479

P. O. Address East St. Louis, Ill.

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.