

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008974

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2258** STATE FILE NUMBER

FILED MAR 7 1962

VS 300 Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 67 years	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5570 Cabanne Ave.		d. STREET ADDRESS (If outside, give location) 5570 Cabanne Ave.	
3. NAME OF DECEASED (Type or print) First Daisy Middle Evelyn Last Wootten		4. DATE OF DEATH Month February Day 25 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-24-1894
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY St. Louis Public Schools	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Hinton K. Wootten		13b. MOTHER'S MAIDEN NAME Ethel Rieff	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Marie K. Wootten, 5570 Cabanne Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency DUE TO (b) Poly cythemia DUE TO (c) Pulmonary fibrosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.) 525x	
20c. TIME OF INJURY Hour a.m. p.m.		20f. CITY, TOWN, OR LOCATION COUNTY, STATE	
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.)	
21. I attended the deceased from May-1947 to Feb-25-62 and last saw her/him alive on 2-24-62 Death occurred at 6:15 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Hanford Phillips M.D.		22b. ADDRESS 6825 Clayton Ave St. Louis	
22c. DATE SIGNED 2-26-62		23. LOCATION (City, town, or county) (State) St. Louis County	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 2-28-1962	
23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24. FUNERAL DIRECTOR Alexander & Sons, 6175 Delmar Blvd.	
25. DATE RECD. BY LOCAL REG. FEB 26 1962		REGISTRAR'S SIGNATURE Roal Smith, M.D.	

(Until 11:00 A.M. Monday or 3:30 to 5:30 P.M. Monday)

Dr. Hanford Phillips

~~xxxxxx~~ 6825 Clayton AVE.

~~xxxxxx~~ MI 7-6313

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 Jos. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6175 Palmer

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.