

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008975

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2132**
FILED MAR 7 1982

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

91

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis MO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis MO		c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION W.D. Horne		d. STREET ADDRESS 1025 Aureka Blvd Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Ward Last Ward		4. DATE OF DEATH Month 1 Day 23 Year 02	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Mo
13a. FATHER'S NAME MR		14. NAME OF HUSBAND OR WIFE Wife	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Helen L. Taylor Address 1300 Clark
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Bronchitis			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pneumonia			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 491x			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 checked="" type="checkbox"/> NO <input 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 7:00 Month, Day, Year 2-15-62		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 St. Louis, Mo.	COUNTY STATE
21. I attended the deceased 7:05 to 7:05 and last saw ^{her} _{him} alive on 2-15-62 . Death occurred at 7:05 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Helen L. Taylor, Coroner (Degree or title)		22b. ADDRESS 1300 Clark Ave.	22c. DATE SIGNED 2-15-62
23a. BURIAL, CREMATION, REMOVAL (Specify) ANATOMICAL BOARD	23b. DATE FEB 28 1962	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Rowland Aker Mortuary Service ADDRESS 4104 Manchester Ave.		25. DATE RECD. BY LOCAL REG. FEB 23 1982	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.