

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

2976

-62-012439

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **FILED MAR 26 1962** Primary Registration District No. Registrar's No.

VS 300  
Rev. 4/59  
1  
2 206  
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4 3  
5 2  
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7 1  
8 2  
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12 97-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4745 St. Louis	
3. NAME OF DECEASED (Type or print) First Middle Last Lula Baskins		4. DATE OF DEATH Month Day Year 3 14 62	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-10-83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (last birthday) 78 YRS
11a. FATHER'S NAME Julius Mason		11b. MOTHER'S MAIDEN NAME FANNIE SHIVERS	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		13. SOCIAL SECURITY NO. ERA COLLINS 4745 ST LOUIS MO	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		15. IF UNDER 1 YEAR Month Days Hours Min. 4	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		16. CITIZEN OF WHAT COUNTRY U.S.A.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Colon		17. NAME OF HUSBAND OR WIFE 491 X H	
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"/>	
20c. TIME OF INJURY Hour s.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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 1-29-62 to 3-14-62 and last saw her alive on 3-14-62		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
22a. SIGNATURE J. D. Dickson MD		22b. ADDRESS 2601 N. Whittier Street	
22c. DATE SIGNED 3-16-62		21. Death occurred at 7:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 3-19-62	
24. FUNERAL DIRECTOR A.F. WALTON		23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON	
25. DATE RECD. BY LOCAL REG. MAR 19 1962		23d. LOCATION (City, town, or county) (State) ST. LOUIS city MO	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		27. REGISTRAR'S SIGNATURE	

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 \_\_\_\_\_

*not Embalmed*

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.