

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012673

3660

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED APR 12 1962

VS 300
Rev. 4/59

1

2 **21**

3

4 **2**

5 **1**

6

7 **0**

8 **2**

9

10

11

12 **77-0**

13

77

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 12 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 4209a West Finney | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Wilkins Middle Last Getter | | | 4. DATE OF DEATH Month 4 Day 4 Year 62 | | | 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 9/21/11 | | 9. AGE (last birthday) 50 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY Self Employed | | | |
| 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | | 13a. FATHER'S NAME Wilkins Getter, Sr. | | 13b. MOTHER'S MAIDEN NAME Cora Mims | | 14. NAME OF HUSBAND OR WIFE Martha Getter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Martha Getter | | Address 4209a W. Finney Ave. | | | | | |
| 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) Probable Carcinoma of Colon (Rectosigmoid) | | | | | | | | | | Undet. | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | 154X | | | |
| DUE TO (b) | | | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | | | |
| 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 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 3-22-62 to 4-4-62 and last saw her/him alive on 4-4-62 | | Death occurred at 5:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Sydney C. Frason</i> | | | | 22b. ADDRESS 2601 N. Whittier | | | | 22c. DATE SIGNED 4/5/62 (State) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 4/9/62 | | 23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery | | 23d. LOCATION (City, town, or county) St. Louis County, Mo. | | | | | | | |
| 24. FUNERAL DIRECTOR G. Wade Granberg | | | | ADDRESS 4202 Finney Ave. | | 25. DATE RECD. BY LOCAL REG. APR 6 1962 | | 26. REGISTRAR'S SIGNATURE <i>Loan 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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.