

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012703
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED **F**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3493**

LED APR 6 1962

VS 300
Rev. 4/59

1
2 **220**
3
4 **3**
5 **2**
6
7 **1**
8 **1**
9
10
11
12 **77-0**
13

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 St. Louis		Length of stay in 1b 59 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Missouri		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) 2703 St. Louis Ave.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosa Grant			First Middle Last			4. DATE OF DEATH Month Day Year 3 29 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 12-8-1897		9. AGE (last birthday) 64		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 3 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Memphis, Tenn.		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Henry (unknown)				13b. MOTHER'S MAIDEN NAME Rosie Matthews				14. NAME OF HUSBAND OR WIFE			
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. No		17. INFORMANT Henry Grant			Address 2825a Easton 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) Cerebral Embolism										INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)											
DUE TO (c) 332x											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Polycythemia								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 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 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 3-27-62 , to 3-29-62 and last saw her ^{her} _{app} alive on 3-29-62				Death occurred at 1:55 p. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Raymond A. Fraser, M.D.</i> (Degree or title)				22b. ADDRESS 2601 N. Whittier Street				22c. DATE SIGNED 4-2-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-3-1962		23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) St. Louis Co. Mo.		(State)			
24. FUNERAL DIRECTOR J. H. Randle & Son				ADDRESS 3133 Bell Ave.		25. DATE RECD. BY LOCAL REG. APR 2 1962		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>			

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 Esther K. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Washington

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.