

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012826

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

318 1003 3141  
FILED APR 6 1962

VS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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) 4628 Kennerly	
3. NAME OF DECEASED (Type or print) First Middle Last Albert James		4. DATE OF DEATH Month Day Year 3 20 62	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-2-1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		11. BIRTHPLACE (City and state or country) Tennessee	
13a. FATHER'S NAME Albert James		13b. MOTHER'S MAIDEN NAME Unknown	
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. 488-05-1995	
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 Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Essential Hypertension 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		17. INFORMANT Mrs. Annie Ward 8317 5th Street	
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 3-16-62 to 3-20-62 and last saw him alive on 3-20-62 Death occurred at 5:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deed or title) Ardney A. Enright, M.D.	
22b. ADDRESS 2601 N. Whittier Street		22c. DATE SIGNED 3-21-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-26-62	
23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR 5010 Enright Metropolitan Funeral System, Inc.		25. DATE RECD. BY LOCAL REG. MAR 23 1962	
26. REGISTRAR'S SIGNATURE Karl Smith, M.D.			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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**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

*John R. Cunningham*

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus 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.