

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-013093  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3662**

**FILED APR 12 1962**

VS 300  
Rev. 4/59

1

2 **21**

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4 **0**

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11

12 **53-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Missouri</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>4302 DeTonty St.</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harold H. Prough</b>			4. DATE OF DEATH Month Day Year <b>April 5, 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/1910</b>
9. AGE (last birthday) <b>51</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Officer - St. Louis</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metropolitan Police</b>	11. BIRTHPLACE (City and state or country) <b>Steelville, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>Jack Prough</b>	
13b. MOTHER'S MAIDEN NAME <b>Della Conoway</b>		14. NAME OF HUSBAND OR WIFE <b>Margarete</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		17. INFORMANT Address <b>Margarete Prough, 4302 DeTonty St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b>			
DUE TO (c) <b>4201</b>			
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 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.	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 <b>1959</b> to <b>4-4-62</b> and last saw her/him alive on <b>4-4-62</b> Death occurred at <b>7:30 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Wilton Davis M.D.</b>		22b. ADDRESS <b>3720 Washington St. L.M.</b>	22c. DATE SIGNED <b>4-6-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-8-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>East View Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Union City, Tenn.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 6 1962</b>	REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b>

**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 J. Haines

Licensed Embalmer No. 4108

P. O. Address St. Louis, Mo

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.