

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017307

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3954**

FILED APR 25 1962

VS 300  
Rev. 4/59

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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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, Mo.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b>		d. STREET ADDRESS (If outside, give location) <b>1470 N. UNION</b>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>BARNEY</b> Middle <b>STONE</b> Last <b>STONE</b>		Month <b>APRIL</b> Day <b>15</b> Year <b>1962</b>	
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
<b>MALE</b>	<b>colored</b>		<b>12-28-03</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday)
<b>BAKER HELPER</b>		<b>BAKERY</b>	<b>58 yrs</b>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	11. BIRTHPLACE (City and state or country)
<b>TOM STONE</b>		<b>LUCY BISHAM</b>	<b>MILAN, TENN</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY
<b>NO</b>			<b>U.S.A</b>
14. NAME OF HUSBAND OR WIFE		17. INFORMANT Address	
<b>HELEN STONE</b>		<b>Helen Stone 1470 N. UNION</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>CHRONIC POLYARTROSIS</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) <b>726.3</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.
<b>ASHD Bronchopneumonia</b>			<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	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
Month, Day, Year	20f. CITY, TOWN, OR LOCATION		
	COUNTY		
	STATE		
21. I attended the deceased from <b>4-11-62</b> to <b>4-15-62</b> and last saw her/him alive on <b>4-15-62</b>			
Death occurred at <b>7:45</b> <b>a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
<b>J. E. Smith M.D.</b>		<b>1515 LAFAYETTE AVENUE</b>	<b>4-15-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>REMOVAL</b>	<b>4-20-62</b>	<b>GREENWOOD CEM</b>	<b>ST. LOUIS CITY, MO</b>
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<b>A.F. WALTON 2707 Stoddard</b>		<b>APR 16 1962</b>	<b>Joan Smith, M.D.</b>

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

*M. Claude Gordon*

Licensed Embalmer No.

*3489*

P. O. Address

*1123 N. Taylor*

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.