

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020464

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4696** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 23 1962

1. PLACE OF DEATH a. COUNTY <del>St. Louis</del>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <del>St. Louis</del>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>33 days</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) <b>St. Louis Children's Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3002 St. Vincent</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>DARRYL</b> Middle <b>WAYNE</b> Last <b>HAGGARD</b>			4. DATE OF DEATH Month <b>5</b> Day <b>7</b> Year <b>62</b>		
--	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-59</b>	9. AGE (last birthday) <b>3yrs.</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>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
--	--	---	---

13a. FATHER'S NAME <b>George H. Haggard</b>	13b. MOTHER'S MAIDEN NAME <b>Betty Fritz</b>	14. NAME OF HUSBAND OR WIFE <b>Single</b>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Ann Pryor 500 So. Kingshighway</b> Address <b>St. Louis, Missouri</b>
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest Respiratory Failure</b> DUE TO (b) <b>Congenital Heart Disease - Tetralogy of Fallot Post-operative Blalock Procedure</b> DUE TO (c) <b>Playlock Procedure</b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>754.0</b>		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.) <b>754.0</b>	
---	---	--	--

20c. TIME OF INJURY Hour Month, Day, Year <b>9:15 AM</b>	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 <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
--	--	--	--	----------------------------	---------------------

21. I attended the deceased from <b>4-2-62</b> to <b>5-7-62</b> and last saw him alive on <b>5-7-62</b> Death occurred at <b>9:15 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE <b>Malcolm Garber MD</b> (Degree or title)	22b. ADDRESS <b>500 So. Kingshighway St. Louis, Missouri</b>	22c. DATE SIGNED <b>5-7-62</b>
--	---	-----------------------------------

23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <b>BURIAL</b>	23b. DATE <b>5-9-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Potosi, Mo.</b>
--	----------------------------	---	---

24. FUNERAL DIRECTOR <b>Sparks Potosi, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 7 1962</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b>
---	---	---

VS 300 Rev. 4/59

1

2 **2/79**

3

4 **0**

5 **0**

6

7 **0**

8 **1**

9

10

11

12 **84-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**84**

**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 Ronald Sparks

Licensed Embalmer No. 4819

P. O. Address Potomac, Md.

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.