

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020841

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4514** STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY ~~St. Louis~~
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Mo.** Length of stay in 1b
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **1282 Hamilton** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **1282 Hamilton** Inside Limits Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
Walter L Perry **4 30 62**
 5. SEX **M** 6. COLOR OR RACE **Negro** 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH **5/31/14** 9. AGE (last birthday) **47** IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **poter** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **Miss** 12. CITIZEN OF WHAT COUNTRY **U. S. A.**

13a. FATHER'S NAME **Will Perry** 13b. MOTHER'S MAIDEN NAME **Syreatha Pleasant** 14. NAME OF HUSBAND OR WIFE **Mosetta Perry**

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. **2** 17. INFORMANT Address **Willie White 1282 Hamilton**

18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Coronary occlusion as a result of marked aortic plus congestive Failure 023X**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
 20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 _____ and last saw her/him alive on _____ Death occurred at **10¹⁰ P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Carl Smith M.D.** 22b. ADDRESS **1300 Clark** 22c. DATE SIGNED **5-1-62**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **5/5/62** 23c. NAME OF CEMETERY OR CREMATORY **Father Dickson** 23d. LOCATION (City, town, or county) (State) **St Louis Co**

24. FUNERAL DIRECTOR ADDRESS **Whitney Funeral Home 3882 Delmar** 25. DATE RECD. BY LOCAL REG. **MAY 2 1962** 26. REGISTRAR'S SIGNATURE **Carl Smith, M.D.**

VS 300 Rev. 4/59
 1
 2 **2059**
 3
 4 **2**
 5 **1**
 6
 7 **1**
 8 **1**
 9
 10
 11
 12 **90-3**
 13

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ
 INSTEAD OF

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

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 F. A. Green

Licensed Embalmer No. 296.3

P. O. Address 4214 Belmont

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.