MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-020925

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5252 STATE FILE NUMBER

FILED MAY 31 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2612½ Cole — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Charlotte — Middle — Last Ross

4. DATE OF DEATH: Month 5 Day 21 Year 62

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 7-20-16

9. AGE (last birthday): 45 — 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): LABORER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): COLUMBUS, MISS.

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: HARRISON HUMPHERIES

13b. MOTHER'S MAIDEN NAME: LAURA GASPIN

14. NAME OF HUSBAND OR WIFE:

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.:

17. INFORMANT: JEAN HUGHES — Address: 1314 BIDDLE

MEDICAL CERTIFICATION

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 Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 334X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Anemia, Diabetes Mellitus, Uterine Fibroma

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 a.m. p.m. Month, Day, Year

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 5-11-62, to 5-21-62 and last saw her alive on 5-21-62
Death occurred at 9:20 a.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Sydney A. Fraser, M. D.

22b. ADDRESS: 2601 N. Whittier Street

22c. DATE SIGNED: 5-21-62

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 5-25-62

23c. NAME OF CEMETERY OR CREMATORY: GREENWOOD

23d. LOCATION (City, town, or county) (State): ST. LOUIS CO, MO.

24. FUNERAL DIRECTOR — ADDRESS: ANDERSON, 4481 FINNEY AVE

25. DATE RECD. BY LOCAL REG.: MAY 24 1962

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

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 4476 Hammell Pl.

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.