

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-021051

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5423**

**FILED JUN 7 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

Original: Blue to prevent disease DOCUMENT BY AFFIDAVIT OF

YOUNG USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY		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) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3667 SHENANDOAH</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>STOVALL</b> Last						4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>1962</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 27, 1891</b>		9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE WORKER INTERNATIONAL SHOE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>			
13a. FATHER'S NAME <b>G.K. STOVALL</b>				13b. MOTHER'S MAIDEN NAME <b>MARTHA WALLACE</b>				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 serv) <b>YES WORLD WAR I</b>						16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARY SCHEINING 6432 HANCOCK</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>Septicemia</b>											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b) <b>Urthral injury</b>											
DUE TO (c) <b>6/12x</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 checked="" 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 Hour a.m. p.m.		Month, Day, Year									
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>4/30/62</b> to <b>5/29/62</b> and last saw her alive on <b>5/29/62</b> Death occurred at <b>5/30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						22a. SIGNATURE <i>James Young M.D.</i>		22b. ADDRESS <b>1515 LAFAYETTE AVE</b>		22c. DATE SIGNED <b>5/29/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>MAY 31 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK GROVE CEMETERY</b>		23d. LOCATION (City, town, or county) <b>ST. LOUIS 90 MO.</b>					
24. FUNERAL DIRECTOR <i>Thomas Hutis 2906 Gravois</i>				25. DATE RECD. BY LOCAL REG. <b>MAY 31 1962</b>		26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i>					

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gravois

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.