

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-021235  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1435

**FILED MAY 21 1962**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

440 43  
240 43

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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

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY: (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wellston</u>		Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>Wellston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1575 Valle Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1575 Valle Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Harmon</u> Last <u>Bone</u>			4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-02</u>
9. AGE (last birthday) <u>60</u>		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) <u>Maintenance Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington University Reynolds Co. Mo.</u>	11. BIRTHPLACE (City and state or country) <u>U. S. A.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Walker P. Bone</u>	13b. MOTHER'S MAIDEN NAME <u>Florence E. Heaston</u>
14. NAME OF HUSBAND OR WIFE <u>Lettie Bone</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address <u>Vernon Bone, 8846 Forest (14)</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>9 MONTHS</u>
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 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 <u>NOV. 28, 1950</u> to <u>APRIL 21, 1962</u> and last saw her/him alive on <u>APRIL 21, 1962</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>C. O. Vermillion, M. D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>5/10/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-11-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CHLORIDE, CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>Chloride, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Shepard Funeral Home, 1167 Hamilton Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>5-10-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

