

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-024428

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** #1985542 SL#28721 Primary Registration District No. **1003** Registrar's No. **6309** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 2 1962

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Rev. 4/59

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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		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY St. Louis		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
ST. LOUIS, MISSOURI		ST. LOUIS, MISSOURI		3 days		FLORISSANT		FLORISSANT		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
VAH, ST. LOUIS, MISSOURI				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		1690 FLORISSANT PARK DR.				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		Month Day Year		
BOYD			BOYD		BONE		BONE		JUNE 24		1962		
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR	
MALE		WHITE				3/27/93		69		Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
FARMER (RETIRED)				-----				GRAVES, KENTUCKY		USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE					
AARON BONE				PERCELLA CAMPBELL				WIDOWED					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
YES				WW I		UNKNOWN		SYLVIA HEISNER SEE 2D					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)										ASPIRATION PNEUMONIA			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b)			
										CEREBRAL VASCULAR ACCIDENT			
										DUE TO (c)			
										CEREBRAL ARTERIOSCLEROSIS			
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.					
								331X		<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					
VA		6/21/62		6/24/62		XX		6/24/62					
21. // attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ 1:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE				22b. ADDRESS				22c. DATE SIGNED					
Gerald F. Peppers M.D.				VAH, ST. LOUIS, MO.				6/24/62					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)					
Removal		6-27-1962		National Cemetery JB		St. Louis Co, Mo.							
24. FUNERAL DIRECTOR				ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
The Florissant Mortuary, Florissant, Mo.						JUN 26 1962		Loan 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 *Gene A. Hutchens*

Licensed Embalmer No. 4966

P. O. Address Florissant, Mo.

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.