

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025268

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary-Registration District No. **1003** Registrar's No. **6372** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 6 1962

VS 300
Rev. 4/59

1
2 **224**
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4 **0**
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MC DONOUGH
USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO		b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1.						Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3906 CALIFORNIA				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Eugene Middle Torrence Last						4. DATE OF DEATH Month June Day 25 Year 1962		5. SEX M		6. COLOR OR RACE W		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-21-01		9. AGE (last birthday) 60		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC						10b. KIND OF BUSINESS OR INDUSTRY Body Shop				11. BIRTHPLACE (City and state or country) Troy Tenn.				12. CITIZEN OF WHAT COUNTRY USA							
13a. FATHER'S NAME George TORRENCE						13b. MOTHER'S MARDEN NAME MARtha Wade						14. NAME OF HUSBAND OR WIFE Nell									
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 Nell TORRENCE Address 3906 Cal									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rt Lung												INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 163X																					
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. <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 Month, Day, Year a.m. p.m.																					
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 5/22/62 to 6/25/62 and last saw her/him alive on 6/25/62 Death occurred at 7:20 PM on the date stated above, and to the best of my knowledge, from the causes stated.																					
22a. SIGNATURE (Degree or title) John Mc Donough M.D.						22b. ADDRESS 1515 Lafayette Ave.						22c. DATE SIGNED 6/26/62									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)													
Burial		6/28/62		St. Matthews				St. Louis, MO													
24. FUNERAL DIRECTOR Rea Land Aker ADDRESS 4406 Manchester						25. DATE RECD. BY DEPT. REG. JUN 27 1962		26. REGISTRAR'S SIGNATURE Rea 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 Phillip H. Golden

Licensed Embalmer No. 5170

P. O. Address St. Louis, 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.