

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-028539

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6858

**FILED JUL 31 1962**

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO.</u> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>ST. LOUIS, MO.</u>                      |  | c. CITY OR TOWN <u>ST. LOUIS</u>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #. I</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>1204 HICKORY</u>   |  |

|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>HAROLD</u> Middle <u>BOY</u> Last <u>COLLINS</u>                        |                                  |  | 4. DATE OF DEATH<br>Month <u>6</u> Day <u>30</u> Year <u>62</u>    |  |   |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>NEGRO</u> | 7. Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/29/62</u>                                 | 9. AGE (last birthday)<br>Months <u>1</u> Days <u>1</u> Hours <u>31</u> Min. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>no</u> |
| 10a. USUAL OCCUPATION   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>   | 11. BIRTH PLACE (City and state or country)<br><u>ST. LOUIS MO</u> | 12. CITIZEN OF WHAT COUNTRY  |   |
| 13a. FATHER'S NAME<br><u>UNKNOWN</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>LEAONA MARLENE COLLINS</u>   |  | 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)<br><u>NONE</u> |                                  |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>                             | 17. INFORMANT Address<br><u>ST. LOUIS CITY HOSP. #1.</u>                     |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Premature Twin Birth

DUE TO (b) Congenital Atelectasis

DUE TO (c) 762.5

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.  
 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 9:07 a.m. Month, Day, Year 6-29-62

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 ST. LOUIS COUNTY ST. LOUIS STATE MO.

21. I attended the deceased from 6-29-62 to 6-30-62 and last saw her/him alive on 6-30-62

Death occurred at 9:07 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) M.D.

22b. ADDRESS 1515 LAFAYETTE AVE

22c. DATE SIGNED 6-30-62

23a. BURIAL, CREMATION, REMOVAL (Specify) JUL 31 1962

23b. NAME OF CEMETERY OR CREMATORY Anatomical Board

23c. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR Rowland Mortuary Evc. ADDRESS 4104-06 Manchester

25. DATE RECD. BY LOCAL REG. JUL 31 1962

26. REGISTRAR'S SIGNATURE [Signature]

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

DR. KHATOON

USE BLACK INK OR TYPEWRITER RIBBON

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.