

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028743

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7577** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

USE BLACK INK OR TYPEWRITER RIBBON

SHOULD READ

BY AFFIDAVIT OF

1. FILED AUG 13 1962		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE Illinois b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 34 days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. JOHN'S HOSP.		c. CITY OR TOWN Chester Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 1125 George St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALAN KEITH HERD			4. DATE OF DEATH Month Day Year July 31, 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-26-62
9. AGE (last birthday) 0		IF UNDER 1 YEAR Months 1 Days 5	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Red Bud, Ill.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Carroll Herd	
14. MOTHER'S MAIDEN NAME Donna Hunt		15. NAME OF HUSBAND OR WIFE none	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Carroll Herd, Chester, Ill.		Address	
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) Asphyxia due to Aspiration?		<input checked="" type="checkbox"/> min	
DUE TO (b) Multiple Congenital Anomalies		Congenital	
DUE TO (c) including: - 759.3			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cleft Lip & Palate, Polydactyly		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 checked="" type="checkbox"/> NO <input 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			
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 June 28, 1962 to July 31, 1962 and last saw ^{her} him alive on July 31, 1962			
Death occurred at 12:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James A. Dowdy M.D.		22b. ADDRESS 6944 Chippewa St. L. Mo.	
22c. DATE SIGNED 1 Aug 62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-2-62	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City, town, or county) Chester, Ill.	
23e. FUNERAL DIRECTOR Paul Welge, Chester, Ill.		23f. ADDRESS	
25. DATE RECD. BY LOCAL REG. AUG 2 1962		26. REGISTRAR'S SIGNATURE Roan 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 *Not Embalmed*
Student _____
Signature of Student Embalmer _____

Signed *John J. Hassly III*

Licensed Embalmer No. *5039*

P. O. Address *East St Louis, Ill.*

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.