

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6796 =62-029075
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED JUL 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		ST. LOUIS, MISSOURI			Missouri		Crawford		Boorban	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			BARNES HOSPITAL		Yes <input type="checkbox"/> No <input type="checkbox"/>	RR # 1			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
ANNA			BELL	RAY	JULY 9 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			
Female	White		7-26-76	85	Months		Days		Hours	
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			
At Home			-		ILLINOIS		USA			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
Sam Jacobson			Mary Ellen Baker			-				
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			
No			None		Joyce Smith		2305 Vanice			
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) PULMONARY EMBOLUS										36 HOURS
LEFT POPLITEAL THROMBOPHLEBITIS										7 DAYS
DUE TO (b) 463X										
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.
ACUTE MYOCARDIAL INFARCTION SECONDARY TO ARTERIOSCLEROTIC HEART DISEASE										<input type="checkbox"/> Yes <input checked="" 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		
				JULY 18, 1962		JULY 9, 1962		JULY 9, 1962		
21. I attended the deceased from 10:50 A.M. to July 9, 1962 and last saw her/him alive on July 9, 1962. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title)					22b. ADDRESS			22c. DATE SIGNED		
C. D. Vermillion, M.D.					BARNES HOSPITAL			7/10/62		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)		(State)	
Removal		7-12-62		Mt Lebanon			ST. Louis Co		Mo	
24. FUNERAL DIRECTOR				ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE		
O'Sullivan Muehle Krom Jennings Rd				8906		JUL 10 1962		Earl Smith, M.D.		

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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 VE Morris

Licensed Embalmer No. 3360

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.