

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029111

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7364**

FILED AUG 6 1962

VS 300
Rev. 4/59

1

2 *22*

3

4 *1*

5 *2*

6

7 *1*

8 *2*

9

10

11

12 *76-0*

13

76

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

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 lb 353 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Chronic Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS		1234 Dillon St,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH Month Day Year					
Edna			Ross			7			23			62					
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				4-19-78		84		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					
None								Arkansas				U.S.					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE									
Unknown				Unknown				Unknown									
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				Georgia Hall, 508 No. 57th., E. St. Louis, Ill									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												INTERVAL BETWEEN ONSET AND DEATH					
<table style="width: 100%;"> <tr> <td style="width: 30%;">Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</td> <td style="width: 30%;">DUE TO (b)</td> <td style="width: 40%;"></td> </tr> <tr> <td></td> <td>DUE TO (c)</td> <td>420.0</td> </tr> </table>														Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)																
	DUE TO (c)	420.0															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (g)								PART III. If deceased was female was there a pregnancy in last 90 days.									
Stokes-Adams Syndrome								<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 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									
21. I attended the deceased from <u>8-4-61</u> to <u>7-23-62</u> and last saw ^{her} him alive on <u>7-22-62</u>		Death occurred at <u>11:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <i>Am Higgins, M.D.</i>				(Degree or title)				22b. ADDRESS <i>634 N. Grand</i>		22c. DATE SIGNED <i>7-24-62</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)									
Burial		7-27-62		St. Matthews Cemetery		St. Louis, Mo.											
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE											
Albert H. Hoppe, Inc., 4700 Washington Blvd.				JUL 26 1962		<i>Neal Smith M.D.</i>											

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 J. W. Wilkins

Licensed Embalmer No. 3575

P. O. Address 17 Louisiana

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.