

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-032279

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8423** STATE FILE NUMBER

FILED SEP 10 1962

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN BRIDGETON Circle
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JEWISH HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 24 BARBARA Circle
3. NAME OF DECEASED (Type or print) First Middle Last RICK ALLEN BIRDSONG			4. DATE OF DEATH Month Day Year AUG. 4 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 AUG 4, 1962
9. AGE (last birthday) IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min. 7 20	
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) ST. LOUIS, Mo.
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME BOBBIE LEE BIRDSONG	
13b. MOTHER'S MAIDEN NAME ROBERTA MAXINE BASS		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)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Roberta Birdsong 24 Barbara Circle
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PREMATURITY + PRECIPITOUS DELIVERY DUE TO (c) 760.5			INTERVAL BETWEEN ONSET AND DEATH 7 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pneumonia Atelectasis			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 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 9:00 AM Aug 4, 1962 to 4:30 PM Aug 4, 1962 last saw her/him alive on Aug 4, 1962 Death occurred at 4:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James E. Ferris, M.D. (Degree or title)		22b. ADDRESS 101 S. MERVINE Ave Clayton 5, Missouri	22c. DATE SIGNED 8/6/62 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 8-31-1962	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) St. Louis, Mo.
24. FUNERAL DIRECTOR Rowland Mortuary Svc. ADDRESS 4104-06 Manchester	25. DATE RECD. BY LOCAL REG. AUG 30 1962	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

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.