MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032512

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8209

FILED AUG 31 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1
2 22
3
4 0
5 0
6
7 1
8 2
9
10
11
12 76-0
13

76

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
			5/

BY AFFIDAVIT OF

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 11 yrs. 9 mo. 12 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hosp.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 305a Lucas Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: James Middle: Last: Harris

4. DATE OF DEATH: Month 8 Day 13 Year 62

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-1-70
9. AGE (last birthday): 92
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Ky.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: William
13b. MOTHER'S MAIDEN NAME: Unk.
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: Chronic Hosp. Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASHD
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.0 H

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): CA of PROSTATE

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 a.m. p.m. Month, Day, Year
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 COUNTY STATE

21. I attended the deceased from 11-2-50, to 8-13-62 and last saw her/him alive on 8-13-62
Death occurred at 7:30 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Kenneth Price MD (Degree or title)
22b. ADDRESS: 5600 Arsenal
22c. DATE SIGNED: 8-13-62

23a. BURIAL, CREMATION, REMOVAL: Rowland-Aker Mortuary Service
23b. DATE: 8-31-1962
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: 4104 Manchester Ave. ADDRESS St. Louis 10, Mo.
25. DATE RECD. BY LOCAL REG.: AUG 23 1962
26. REGISTRAR'S SIGNATURE: Earl 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.

Student_____ Signed_____
Signature of Student Embalmer

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.