

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032530

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7799**

FILED AUG 22 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4361 Maffitt Avenue Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lee Middle Harmon Last Herrod		4. DATE OF DEATH Month 8 Day 8 Year 1962	
5. SEX Male	6. COLOR OR RACE Colored	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-19-1956
9. AGE (last birthday) 5		IF UNDER 1 YEAR Months 9 Days 19	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Arkansas
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Joe Herrod	
13b. MOTHER'S MAIDEN NAME Larla Micia		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Address: Joe Herrod 4361 Maffitt Avenue
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage and intra-ventricular hemorrhage of the brain; suffered when deceased was struck by car operated by one Cynthia Thompson, in front of about 2805 N. Newstead about 5:25 P.M August 3rd, 1962. DUE TO (b) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) Accident			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)			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 checked="" 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.) See above	
20c. TIME OF INJURY 5:25 a.m. Hour 8-3-62 Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT-WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 11 St. Louis, Mo		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at 12:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul J. Simon Deputy Coroner		22b. ADDRESS 1301 Clark	
22c. DATE SIGNED 8/9/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-11-1962	23c. NAME OF CEMETERY OR CREMATORY Greenwood	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR Ellis Funeral Home, Inc.		ADDRESS 2820 Stoddard St.	25. DATE RECD. BY LOCAL REG. AUG 9 1962
			26. REGISTRAR'S SIGNATURE Paul 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 _____
Signature of Student Embalmer

Signed *Fullton E. Calkin*

Licensed Embalmer No. 4198

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.