

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032597

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

7867

FILED AUG 22 1962

VS 300
Rev. 4/59

1

2 21 5

3

4 0

5 1

6

7 0

8 2

9

10

11

12 92-0

13

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 DOA		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
St. Louis		St. Louis		DOA		Mo.		Mo.		St. Louis		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS				(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
City Hospital						4540 Nebraska						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. SEX			6. COLOR OR RACE			
First Middle Last						Month Day Year			M W			W			
Arley S. Kennedy						8/ 9 62									
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
M		W				1/21/21		41							
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			
Bus operator				Greyhound				Perkins Mo.				USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
William				Ida London				Jewel							
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							
yes						2WW		Jewel Kennedy 4540 Nebraska							
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <i>acute massive myocardial infarction</i> 24hr															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary sclerosis</i> 6mo															
DUE TO (c) <i>generalized arteriosclerosis</i> 12mo															
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.					
<i>Gastritis and duodenitis 420.1</i>										<input type="checkbox"/> Yes <input 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				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			
Hour Month, Day, Year a.m. p.m.															
21. I attended the deceased from <i>8-6-62</i> to <i>8-9-62</i> and last saw ^{her} him alive on <i>8-9-62</i>															
Death occurred at <i>3:30P</i> m 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			
<i>Dominic J. Verda M.D.</i>						<i>4500 O live St</i>						<i>8-10-62</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)							
removal		8/12/62		Memorial Cemetery				Fredericktown Mo.							
24. FUNERAL DIRECTOR ADDRESS						25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE							
Schumacher 3013 Meramec						AUG 10 1962		<i>Coal Smith, M.D.</i>							

AUG 31 1962

DR. D. VERDA 4500 Olive
HO 7-8400

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 Jack Haept
Licensed Embalmer No. 4746

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.