

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-032946

8212

STATE FILE NUMBER

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

FILED AUG 31 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1

2 **223**

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12 **75**

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
		ST. LOUIS, MO.								ST. LOUIS, MO		Yes <input 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 type="checkbox"/>									
						ST. LOUIS CITY HOSP. #1				1827 SO. 17th ST.									
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH		Month		Day		Year	
			MICHAEL						STROLLO			8		7		62			
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR							
MALE		WHITE				3 9		77		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							
UNKNOWN				UNKNOWN				MISSISSIPPI				U.S.A							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE											
NICK				MARY															
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				NO				???				ST. LOUIS CITY HOSP. #1.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Pneumonia																			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.																			
DUE TO (b) _____																			
DUE TO (c) _____												491X							
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.									
CHRONIC PNEUMONIA										<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		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					
								8/3/62				8/7/62		8/7/62					
21. I attended the deceased from _____, to _____ and last saw her him alive on _____																			
Death occurred at _____ 11:18 PM _____ 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>J. E. D...</i> M.D.						1515 LAFAYETTE AVE.						8/7/62							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, county) (State)													
Rowland-Aker Mortuary Service		8-1-1962		Anatomical Board		St. Louis, MO.													
24. FUNERAL DIRECTOR'S NAME AND ADDRESS						25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE											
3004 Manchester Ave. St. Louis 10, Mo.						AUG 23 1962		<i>Roal Smith, M.D.</i>											

BRITTINGHAM 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.