MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-032954
8199
STATE FILE NUMBER

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

FILED AUG 31 1952

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 15 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 5872 Cates Ave
Inside Limits: Yes ☐ No ☐ X

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐ XX
d. STREET ADDRESS (If outside, give location): 5872 Cates Ave
Reside on Farm: Yes ☐ No ☐ X

3. NAME OF DECEASED (Type or print): First PHOEBE Middle Last SYLVESTER

4. DATE OF DEATH: Month Aug Day 19 Year 1962

5. SEX: Female
6. COLOR OR RACE: Col
7. Married ☐ Never Married ☐ Widowed ☐ X Divorced ☐
8. DATE OF BIRTH: 5-7-1890
9. AGE (last birthday): 72
IF UNDER 1 YEAR: Months 3 Days 12
IF UNDER 24 HR: Hours Min.

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

13a. FATHER'S NAME: Aaron Barnes
13b. MOTHER'S MAIDEN NAME: Katie ?
14. NAME OF HUSBAND OR WIFE: *

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Gertrude Reese 5872 Cates Ave
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): Chronic hypocardia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 422.2
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.
☐ 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 1958, to Aug. 19th 62 and last saw her/him alive on Aug. 18-1962
Death occurred at 2-A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. W. Wilkerson (Degree or title) MD
22b. ADDRESS: 4141 Page
22c. DATE SIGNED: 8-20-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8-24-1962
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county): St. Louis Co (State) Mo

24. FUNERAL DIRECTOR: JAS H. RANDLE & SON
ADDRESS: 3133 Bell Ave
25. DATE RECD. BY LOCAL REG.: AUG 21 1962
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

OCT 16 1962

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 Esther H. Harris

Signature of Student Embalmer

Licensed Embalmer No. 4458

P. O. Address 4181 Washington

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.