

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-033027

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8188

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 31 1962

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1					
2 <u>22</u>					
3					
4 <u>3</u>					
5 <u>0</u>					
6					
7 <u>0</u>					
8 <u>2</u>					
9					
10					
11					
12 <u>75-0</u>					
13					
<u>75</u>	SHOULD READ	ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	

KHATOON
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, Mo.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp.#1				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2141 DIVISION				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Boy Middle Williams Last JR. Baby xx CARL						4. DATE OF DEATH August 17, 1962 Month August Day 17 Year 1962							
5. SEX MALE		6. COLOR OR RACE NEGRO		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH AUG. 16, 1962		9. AGE (last birthday) Months 17 Days 17 Hours 30 Min.		IF UNDER 1 YEAR		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME CARL WILLIAMS				13b. MOTHER'S MAIDEN NAME LILLIAN NOAH				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) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT ST. LOUIS CITY HOSP.#1 Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)													
DUE TO (c) 776x													
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 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 _____ a.m. _____ p.m. _____		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	
21. I attended the deceased from 8-16-62 to 8-17-62 and last saw her/him alive on 8-17-62				Death occurred at 5:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Khatoon M.D.</i> (Degree or title)						22b. ADDRESS 1515 Lafayette Ave				22c. DATE SIGNED 8-17-62			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-31-62		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.							
24. FUNERAL DIRECTOR Rowland Mortuary Svc. ADDRESS 4104-06 Manchester				25. DATE RECD. BY LOCAL REG. AUG 23 1962		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>							

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.