

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036188

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **8506**

8506

FILED SEP 17 1962

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>10 Days</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>		c. CITY OR TOWN <b>East St. Louis, Illinois</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>20-A John DeShields Homes</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>HILL</b> Middle <b>GOLLIDAY</b> Last <b>GOLLIDAY</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>31</b> Year <b>1962</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/1906</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>		11. BIRTHPLACE (City and state or country) <b>Grenada, Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>				
13a. FATHER'S NAME <b>MAC GOLLIDAY</b>				13b. MOTHER'S MAIDEN NAME <b>LOVIE STOVER</b>			14. NAME OF HUSBAND OR WIFE <b>DORA GOLLIDAY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [(If yes, give war or dates of service)] <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Dora Golliday, 20-A John DeShields Homes</b>						
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) <b>CEREBRAL VASCULAR ACCIDENT</b>										<b>1 HOUR</b>		
DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>										<b>MANY YEARS</b>		
DUE TO (c) _____ <b>331X</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROSIS GANGRENE OF RIGHT LEG &amp; DIABETES MELLITUS</b>										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 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 <b>OCT. 19, 1955</b> to <b>AUG. 31, 1962</b> and last saw her/him alive on <b>AUG. 31, 1962</b> Death occurred at _____ <b>8:03</b> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <i>C. D. Vermillion, M.D.</i> (Degree or title) <b>M.D.</b>						22b. ADDRESS <b>BARNES HOSPITAL</b>			22c. DATE SIGNED <b>8/31/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/5/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Gardens of Memory</b>		23d. LOCATION (City, town, or county) <b>Steekey Township, Illinois</b>		(State)				
24. FUNERAL DIRECTOR <i>Marionette</i>		ADDRESS <b>2114 Missouri Ave., St. Louis, Illinois</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 4 1962</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>						

USE BLACK INK OR TYPEWRITER RIBBON

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**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

*Marionette Offner*

Licensed Embalmer No.

5177

P. O. Address

*St. Louis, Ill*

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.