

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-036200
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8833**

FILED SEP 17 1962

1. PART I. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo/ b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		Length of stay in 1b 3yrs. 2mo.	c. CITY OR TOWN St. Louis,
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4425 W. Belle
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Callie Middle W. Last Greene			4. DATE OF DEATH Month September Day 11 Year 1962		
5. SEX Female	6. COLOR OR RACE Color	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1886	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days 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 Marianna		12. CITIZEN OF WHAT COUNTRY U. S. A.	
11a. FATHER'S NAME Robert		11b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Arthur Greene	
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. No	17. INFORMANT Address Robert White 4425 West Belle Pl.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 years
DUE TO (b) Generalized arteriosclerosis		3 years
DUE TO (c) 443x		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Cerebral Thrombosis 2 yrs ago

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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
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21. I attended the deceased from **July 1 1962** to **Sept 11 62** and last saw her alive on **Sept 10 1962**
Death occurred at **9 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B. J. McGinnis M.D. (Degree or title)	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 9-11-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal R.R.	23b. DATE 9-14-1962	23c. NAME OF CEMETERY OR CREMATORY Marianna, Arkansas	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR JAS. H. RANDLE & SON ADDRESS 3133 Bell Ave.	25. DATE RECD. BY LOCAL REG. SEP 12 1962	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

VS 300 Rev. 4/59	DATE AMENDED
1	
2	2/11
3	
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12	76-0
13	

INSTEAD OF DOCUMENT BY AFFIDAVIT OF

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 Esther K. Harris

Licensed Embalmer No. 4458

P. O. Address 418 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.