

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036613

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9173**

FILED OCT 3 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. Louis Mo		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer A. Phillips		d. STREET ADDRESS (If outside, give location) 321 N Boyle	
3. NAME OF DECEASED (Type or print) First MARION Middle RATLIFF Last 77		4. DATE OF DEATH Month 9 Day 23 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker		11. BIRTHPLACE (City and state or country) GARLAND Co. ARK	
13a. FATHER'S NAME unknown		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) Yes World War II		17. INFORMANT Mr. Ray L. Bauer M.D. Ark.	
19. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & fatal toxic cerebral edema, m. achrochiditis		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) 340.3	
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 11:30 Month, Day, Year 9/23/62		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 11:30 A.M. and last saw her alive on 9/24/62 . Death occurred at 11:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Joseph M. Turner		22b. ADDRESS 1300 Oak	
22c. DATE SIGNED 9-24-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/26/62	23c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery	
24. FUNERAL DIRECTOR St. Louis Cemetery ADDRESS 4200 Capital Bldg. St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. 9-24-1962	
		26. REGISTRAR'S SIGNATURE Robert Smith, M.D.	

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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 *[Handwritten Signature]*

Licensed Embalmer No. 3481

P. O. Address *[Handwritten 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.