

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036861

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8998 STATE FILE NUMBER

FILED SEP 24 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

LETTERS  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS, MO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		d. STREET ADDRESS (If outside, give location) <b>4652a Delmar</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle Last <b>White</b>		4. DATE OF DEATH Month <b>9</b> Day <b>15</b> Year <b>62</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Tenn.</b>
13a. FATHER'S NAME <b>Empral Cannon</b>		13b. MOTHER'S MAIDEN NAME <b>Clara Echols</b>	14. NAME OF HUSBAND OR WIFE <b>Alexander White</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>None</b>	17. INFORMANT <b>Elizabeth Arnold Williams 4652 Delmar</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left cerebral hemisphere infarct</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>332X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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. <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 <b>6:30</b> s.m. p.m. Month, Day, Year <b>7-22-62</b>		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>7-22-62</b> , to <b>9-15-62</b> and last saw her/him alive on <b>9-15-62</b> Death occurred at <b>6:30</b> <b>A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Law B. Myers, M.D.</b>		22b. ADDRESS <b>1515 Lafayette Ave.</b>	22c. DATE SIGNED <b>9-15-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>9-20-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National</b>	23d. LOCATION (City, town, or county) (State) <b>J.B. Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Dunn Funeral Home 3847 Page</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 18 1962</b>	26. REGISTRAR'S SIGNATURE <b>Coart Smith, M.D.</b>

**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 Arthur L. Heilbard

Licensed Embalmer No. 4221

P. O. Address 3100 Costley Ave

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.