

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036900

STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8929

FILED SEP 24 1962

VS 300
Rev. 4/59

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5516 Natural Bridge</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elma Wood</u>			4. DATE OF DEATH Month Day Year <u>Sept. 15, 1962</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. Lincoln Engineering Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dexter Missouri</u>	9. AGE (last birthday) <u>61</u>
11a. FATHER'S NAME <u>George McDonald</u>		11b. MOTHER'S MAIDEN NAME <u>Mamie Chambers</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		12b. SOCIAL SECURITY NO. <u>332 X F</u>	
13a. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Paralysis sudden</u>		13b. INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
DUE TO (b) <u>Intra cranial Pressure</u>		DUE TO (c) <u>Cerebral Thrombosis?</u>	
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 checked="" 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.) <u>Patient fell left 11-centured face signs of brain damage 13th</u>	
20c. TIME OF INJURY Hour <u>8:20</u> p.m. Month, Day, Year <u>9-11-62</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>on way to work</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>00</u>
21. I attended the deceased from <u>9-11-62</u> to <u>9-15-62</u> and last saw her alive on <u>9-15-62</u>		Death occurred at <u>11 a.m</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Ingress of title) <u>Harford Phillips M.D.</u>		22b. ADDRESS <u>6825 Clayton ave</u>	22c. DATE SIGNED <u>9-15-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Sept. 16, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dexter City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dexter Missouri,</u>
24. FUNERAL DIRECTOR <u>Lupton Chapel Inc. 7233 Delmar Bl</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 15 1962</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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Dr. H. Phillips
215 Graybridge

OCT 23 1962

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St Louis, Mo.

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.