

MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-040156
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9944**

FILED OCT 29 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. 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) a. STATE Missouri COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| 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 Homer G. Phillips | | d. STREET ADDRESS (If outside, give location) 1399 Belt | |
| 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 James Middle Dorsey, Jr. Last | | | 4. DATE OF DEATH Month 10 Day 9 Year 62 |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-9-62 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) 3 Months 10 Days |
| 11a. BIRTHPLACE (City and state or country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME James Dorsey | | 13b. MOTHER'S MAIDEN NAME Jeanette Kiner | |
| 14. NAME OF HUSBAND OR WIFE | | 17. INFORMANT Mrs. Mary D. Jett, R.R.L., 2601 N. Whittier | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Syndrome (Acute) DUE TO (b) 773.0 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Imperforate Anus & Cysts of Kidney | | | |
| 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.) | | 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 | |
| 20c. TIME OF INJURY Hour 4:45 a.m. p.m. | | 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 10-9-62 to 10-9-62 and last saw him alive on 10-9-62 Death occurred at 4:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Robert White</i> (Name or title) Robert White, M. D. | | 22b. ADDRESS 2601 N. Whittier | |
| 22c. DATE SIGNED 10-11-62 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) 10-31-1962 | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATOR Anatomical Board | |
| 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | 25. DATE RECD. BY LOCAL REG. REGISTRAR'S SIGNATURE 10-18-1962 <i>Roan Smith, M.D.</i> | |
| 24. FUNERAL DIRECTOR Rowland Mortuary Svc. | | 4104-06 Manchester | |

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 _____

Licensed Embalmer No. _____

P. O. 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.