

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040355

318

1003

10045

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED NOV 1 1962

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| 1. PLACE OF DEATH a. 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 Enroute City Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY _____ c. CITY OR TOWN St. Louis. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 3901 Hartford, St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
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| 3. NAME OF DECEASED (Type or print) First Middle Last <p style="text-align: center;">Odie Lynn Huggins</p> | | | 4. DATE OF DEATH Month Day Year <p style="text-align: center;">October 18, 1962</p> | | |
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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10/5/1904 | 9. AGE (last birthday) 58 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | 10b. KIND OF BUSINESS OR INDUSTRY Tower Grove Bank | 11. BIRTHPLACE (City and state or country) Rector, Arkansas. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Charlie Huggins | 13b. MOTHER'S MAIDEN NAME Julia Gallion | 14. NAME OF HUSBAND OR WIFE Lola |
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| 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. Nil | 17. INFORMANT Address Odie V. Huggins, 3918 Folsom, Ave. |
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| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the head with laceration of the right hemisphere of the brain; self inflicted with rifle in home on October 18th, 1962. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO See above | INTERVAL BETWEEN ONSET AND DEATH _____ |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Suicide 976x | 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 10-18-62 | 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.) Home |
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| 20f. CITY, TOWN, OR LOCATION St. Louis, Mo | COUNTY _____ | STATE _____ |
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ **10¹⁷A** _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Heleen L. Taylor, Coroner | 22b. ADDRESS 1300 Clark Ave. | 22c. DATE SIGNED 10-19-62 |
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|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 10-21-62 | 23c. NAME OF CEMETERY OR CREMATORY Woodland Heights Cem. | 23d. LOCATION (City, town, or county) (State) Rector, Arkansas. |
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| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, | 25. DATE RECD. BY LOCAL REG. OCT 19 1962 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. |
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VS 300 Rev. 4/59

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911

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED
INSTEAD OF
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

NOV 8 1962

DEC 5 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 _____

Licensed Embalmer No. 2653

P. O. Address M. Lander

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.