

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040404

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10210 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

318  
FILED NOV 1 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS, MISSOURI</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b <u>2 HRS. 20 MIN.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VAH, ST. LOUIS, MO.</u>		d. STREET ADDRESS (If outside, give location) <u>1120 BAYARD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGIL L. KING</u>		4. DATE OF DEATH Month Day Year <u>10/23/62</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/09</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELEVATOR OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>53</u>
11. BIRTHPLACE (City and state or country) <u>AUGUSTA, ARKAN SAS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>BOYD KING</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISE JOHNSON</u>	
14. NAME OF HUSBAND OR WIFE <u>ARDEANIA KING</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW-II</u>	
16. SOCIAL SECURITY NO. <u>WA-11</u>		17. INFORMANT Address <u>ARDEANIA KING (WIDOW) SEE #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HEMORRHAGE</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>331x</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 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 Month, Day, Year 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. <input checked="" type="checkbox"/> attended the deceased from <u>9/28/62</u> to <u>10/23/62</u> and last saw him alive on <u>10/23/62</u> Death occurred at <u>2:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>JOSEPH P. SCHAEFER M.D.</u>		22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	
22c. DATE SIGNED <u>10/23/62</u>		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-29-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Bks., Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Ellis Funeral Home-2820 Stoddard St.</u>		25. DATE RECD. BY LOCAL REG. REGISTRAR'S SIGNATURE <u>OCT 25 1962</u> <u>Joan Smith, M.D.</u>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 Fulton E. Hickin

Licensed Embalmer No. 4198

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.