

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040627

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9887** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1  
2 **219**  
3  
4 **2**  
5 **1**  
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11  
12 **77-0**  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL-CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. <del>FILED</del> <b>OCT 19 1962</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE <b>Missouri</b>	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in lb		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3927 West Belle</b>
3. NAME OF DECEASED (Type or print)		First <b>Will</b>	Middle <b>Pullen</b>
Last <b>Pullen</b>		4. DATE OF DEATH	
Month <b>10</b>		Day <b>14</b>	
Year <b>62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-9-1880</b>
9. AGE (last birthday) <b>81 YRS</b>		IF UNDER 1 YEAR Months <b>11</b> Days	
IF UNDER 24 HR Hours Min.		11. BIRTHPLACE (City and state or country) <b>PADUCAH, KY</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
10b. KIND OF BUSINESS OR INDUSTRY		14. NAME OF HUSBAND OR WIFE <b>MATTIE PULLEN</b>	
13a. FATHER'S NAME <b>Pete PULLEN</b>		13b. MOTHER'S MAIDEN NAME <b>HARRIETT P</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.	
17. INFORMANT <b>MATTIE PULLEN 3927 W. Belle</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Uremia</b>			<b>Undet.</b>
DUE TO (b) <b>Chronic Pyelonephritis</b>			
DUE TO (c) <b>6000</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease &amp; Incarcerated Rt. Inguinal Hernia</b>			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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 checked="" 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>9-24-62</b> to <b>10-14-62</b> and last saw him alive on <b>10-14-62</b>		Death occurred at <b>5:25 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>James H. Alley, M.D.</b>		22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>10-15-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>REMOVAL</b>	<b>10-19-62</b>	<b>WASHINGTON PARK</b>	<b>ST. LOUIS, CTY MO</b>
24. FUNERAL DIRECTOR	25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE
<b>A.F. WALTON 2707 Stoddard</b>	<b>OCT 16 1962</b>		<b>Roan 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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Taylor

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.