

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

-62-040631

Registration District No. **318** Primary-Registration District No. _____ Registrar's No. **10418** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 13 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY			
VS 300 Rev. 4/59		St. Louis		2 6 yrs	Missouri					
1	c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
2	Homer G. Phillips		Yes <input type="checkbox"/> No <input type="checkbox"/>		4007 Lincoln		Yes <input type="checkbox"/> No <input type="checkbox"/>			
3	3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			
4	Frances					Purnell	Month	Day		
5							10	27		
6							Year			
7							62			
8	5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		
9	Fem.	Negro		3-24-05		57		Months	Days	
10	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		Hours	Min.
11	Domestic		Home		Miss.		U.S.A			
12	13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE			
13	James Woods			Francis Earl			Robert Purnell			
14	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.		17. INFORMANT Address				
15	No					Robert Purnell 2730 Delmar				
16	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
17	IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease									
18	Interval Between Onset and Death: Undet.									
19	Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
20	DUE TO (b) _____									
21	DUE TO (c) _____ 4200									
22	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.			
23							<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown			
24	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)					
25	20c. TIME OF INJURY		Hour a.m. p.m.							
26	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	
27										
28	21. I attended the deceased from 10-17-62 to 10-27-62 and last saw him alive on 10-27-62									
29	Death occurred at 6:15 P. on the date stated above, and to the best of my knowledge, from the causes stated.									
30	22a. SIGNATURE (Type or Print)				22b. ADDRESS			22c. DATE SIGNED		
31	Hittler				2601 N. Whittier			10-29-62		
32	23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
33	Removal		11-3-62		Washington Park		St. Louis Co. Mo.			
34	24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE			
35	Dunn Funeral Home 3847 Page				OCT 30 1962		Earl Smith, M.D.			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DATE AMENDED

DOCUMENT BY AFFIDAVIT OF MEDICAL CERTIFICATION SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO.

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 Arthur L. Hillard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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.