MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10315 -62-040885 STATE FILE NUMBER

FILED NOV 1 1962

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS: DATE AMENDED / INSTEAD OF / SHOULD READ / ITEM NO. / BY AFFIDAVIT OF / DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Inside Limits Yes ☐ No ☐

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 ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4439 West Belle — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Henry Middle Last Wiley
4. DATE OF DEATH: Month 10 Day 25 Year 62
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-13-95
9. AGE (last birthday): 67 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): South Carolina
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Josh Wiley
13b. MOTHER'S MAIDEN NAME: Liza ?
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Susie Caston, Address: 4439 West Belle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremic Acidosis — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Chronic Renal Disease
DUE TO (c): Obstructive Uropathy 603X
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 10-18-62, to 10-25-62 and last saw ~~him~~ alive on 10-25-62
Death occurred at 11:15 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.
22b. ADDRESS: 2601 N. Whittier
22c. DATE SIGNED: 10-26-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Oct 31/62
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson
23d. LOCATION (City, town, or county): St Louis (State): MO

24. FUNERAL DIRECTOR: F.A. Green ADDRESS: 4214 Delmar
25. DATE RECD. BY LOCAL REG.: OCT 29 1962
26. REGISTRAR'S SIGNATURE: Ead Smith, M.D.

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_____ Signed F. A. Green

Signature of Student Embalmer

Licensed Embalmer No. 2963

P. O. Address 4214 Delman

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.