

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040986

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3018

FILED OCT 26 1962

VS 300
Rev. 4/59

1 4002
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Length of stay in 1b 38 Yrs.	c. CITY OR TOWN Ladue Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 36 Pointer Lane Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES BRAY COSTEN			4. DATE OF DEATH Month Day Year Oct. 18, 1962
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 9/23/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Private Praticce	9. AGE (last birthday) 67 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Mc Kensie, Tenn.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Costen		13b. MOTHER'S MAIDEN NAME Eula	14. NAME OF HUSBAND OR WIFE Carolyn E. Costen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Dr. Wm. S. Costen 20 Berkley Lane
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissolving aneurysm of aorta			INTERVAL BETWEEN ONSET AND DEATH 1959
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 a.m. p.m. Month, Day, Year			
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 4/1/59 to death and last saw her/him alive on 10/11/62 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert Davis M.D. (Degree or title)		22b. ADDRESS 3720 Washington	22c. DATE SIGNED 10/22/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/20/1962	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCANON (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS ALEXANDER & SONS 6175 Delmar Blvd. St. Louis 12, Mo,		25. DATE RECD. BY LOCAL REG. 10-19-62	26. REGISTRAR'S SIGNATURE John B. Mumphy M.D.

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH SERVICES
DIVISION OF PROFESSIONAL REGULATION
EMBALMERS

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EMBALMERS

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 J. Allen Davis Jr
Licensed Embalmer No. 4953
P. O. Address 06718-1962

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.