

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

11860

-62-044513

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED DEC 14 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

COZART  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL #1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1819 GEYER AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle Last <u>LAMBERT</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>9</u> - Year <u>62</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 21 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>83</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A.</u>	
13a. FATHER'S NAME <u>WILLIAM PIXLEY</u>		13b. MOTHER'S MAIDEN NAME <u>HARRIET MASON</u>	
14. NAME OF HUSBAND OR WIFE		17. INFORMANT Address <u>PEARL CASTLEBERY 1819 GEYER AVE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>OBESITY</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <u>443K</u>	
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 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 <u>12-8-62</u> to <u>12-9-62</u> and last saw her/him alive on <u>12-9-62</u> Death occurred at <u>11:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>J. E. Cozart MD</u> (Degree or title)	
22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		22c. DATE SIGNED <u>12/9/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>DEC 11 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FLMWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>FLORA ILL</u>
24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 11 1962</u>	26. REGISTRAR'S SIGNATURE <u>Roald Smith, M.D.</u>	

MAR 30 1956

RECEIVED

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 Elean Province

Licensed Embalmer No. 3403

P. O. Address 2906 Ravon

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.