

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044557

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10356

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962

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</u>		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>Laclede Hotel</u>		d. STREET ADDRESS (If outside, give location) <u>Laclede Hotel</u> Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH McCoy</u>			4. DATE OF DEATH Month Day Year <u>SEPT 14 1962</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-1893</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISABLED VETERAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ST. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>PATRICK McCoy</u>		13b. MOTHER'S MAIDEN NAME <u>BRIDGET HASTEY</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>JOHN McCoy 3410 Connecticut</u>	

18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>420.1</u>		
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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Paul J. Simon Deputy Coroner</u>		22b. ADDRESS <u>1308 Clark</u>		22c. DATE SIGNED <u>10/29/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>OCT 30, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL Cem.</u>	
24. FUNERAL DIRECTOR <u>Sharon Katis 2906 Marion</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 29 1962</u>		23d. LOCATION (City, town, or county) (State) <u>JEFFERSON BRKS Mo</u>	
24. REGISTRAR'S SIGNATURE <u>Boad Smith M.D.</u>					

VS 300 Rev. 4/59
1
2 22
3
4 0
5 0
6
7 0
8 1
9
10
11
12 90-3
13

DATE AMENDED
DCC
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

claimed at Cor. 10/29/62
USE BLACK INK OR TYPEWRITER RIBBON
90

STATE OF OHIO

Embalmer

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 *Eleanora Pounce*

Licensed Embalmer No. 3403

P. O. Address 2906 Groves

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.