

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044570

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10944** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<p>FILED NOV 19 1962</p> <p>1. PLACE OF DEATH</p> <p>a. COUNTY St. Louis</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Missouri b. COUNTY _____</p> <p>c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 4942 St. Louis Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print) First Laura Middle _____ Last McKeever</p>		<p>4. DATE OF DEATH Month 11 Day 11 Year 62</p>				
<p>5. SEX Female</p>	<p>6. COLOR OR RACE Negro</p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 8-28-1900</p>	<p>9. AGE (last birthday) 62</p>	<p>IF UNDER 1 YEAR Months _____ Days _____</p>	<p>IF UNDER 24 HR Hours _____ Min. _____</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY - - -</p>		<p>11. BIRTHPLACE (City and state or country) Macon, Miss.</p>		<p>12. CITIZEN OF WHAT COUNTRY USA</p>
<p>13a. FATHER'S NAME Abner Joiner</p>			<p>13b. MOTHER'S MAIDEN NAME Lillie Nichols</p>		<p>14. NAME OF HUSBAND OR WIFE - -</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no</p>		<p>16. SOCIAL SECURITY NO. unknown</p>		<p>17. INFORMANT Address Mrs. Johnnie Calvert - 4854 St. Louis</p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) Intestinal Obstruction</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastatic Carcinoma</p> <p>DUE TO (c) 153.9</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____</p> <p>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</p>						
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p>				
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>				
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		<p>20f. CITY, TOWN, OR LOCATION _____</p>		<p>COUNTY _____ STATE _____</p>		
<p>21. I attended the deceased from 11-6-62 to 11-11-62 and last saw her alive on 11-11-62</p> <p>Death occurred at 3:55 P. m on the date stated above, and to the best of my knowledge, from the causes stated.</p>						
<p>22a. SIGNATURE <i>J. J. Richardson M.D.</i> (Degree or title)</p>			<p>22b. ADDRESS 2601 N. Whittier</p>		<p>22c. DATE SIGNED 11-13-62 (State) 11-13-1962</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Removal</p>		<p>23b. DATE 11-16-62</p>	<p>23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery</p>		<p>23d. LOCATION (City, town, or county) Berkeley, Mo.</p>	
<p>24. FUNERAL DIRECTOR ATKINS BROS. ADDRESS 3644 Finney Ave.</p>		<p>25. DATE RECD. BY LOCAL REG. NOV 14 1962 REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i></p>				

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 John X. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.