

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11670-62-044597
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

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

FILED DEC 14 1962

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED
Rev. 4/59		
1		
2 <u>21</u>		
3		
4 <u>2</u>		
5 <u>1</u>		
6		
7 <u>1</u>		
8 <u>1</u>		
9		
10		
11		
12 <u>58-0</u>	INSTEAD OF	
13		
58	DOCUMENT	
	MEDICAL CERTIFICATION	
	BY AFFIDAVIT OF	
	SHOULD READ	
	ITEM NO.	
	OR	
	TYPEWRITER RIBBON	

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>59 yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		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>DEACONESS HOSPITAL</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4033 Page</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LIMOS</u> Middle <u>MARTIN</u> Last						4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1962</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/15/87</u>		9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>0</u> Days		IF UNDER 24 HR. Hours <u>87</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rock Isl. R.R.</u>		11. BIRTHPLACE (City and state or country) <u>Marion, Ala.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Anderson Martin</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah (unknown)</u>				14. NAME OF HUSBAND OR WIFE <u>Mattie Martin</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.		17. INFORMANT Address <u>Mattie Martin, 4033 Page</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with Metastases</u>										Several years.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) _____			
DUE TO (c) _____										177x			
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 <u>5-22-58</u> to <u>12-1-62</u> and last saw her/him alive on <u>10-21-62</u> Death occurred at <u>Deaconess Hospital 5:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Edw. M. Cannon M.D.</u> (Degree or title)						22b. ADDRESS <u>714 University Club Bldg.</u>			22c. DATE SIGNED <u>12-3-62</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12/6/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>							
24. FUNERAL DIRECTOR <u>Charles J. Gates, Jr., 4107 Finney</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>DEC 5-1962</u>		26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>							

OK
Allen R. Taylor
Coroner 12-5

Form 1-236 (3-31-4)

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 Raymond Dickson, Student Embalmer No. 665
working under my personal supervision.

Student Raymond Dickson
Signature of Student Embalmer

Signed Quinton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Firney

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.