

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044866  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10586

**FILED NOV 19 1962**

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY  |   |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>ST. LOUIS, MO.</u>   |   | c. CITY OR TOWN <u>St. Louis</u>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. # 1</u>   |   | d. STREET ADDRESS (if outside, give location)<br><u>2325 Laselle</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>ALBERT</u> Middle Last <u>SHORT</u>  |   | 4. DATE OF DEATH<br>Month <u>11-</u> Day <u>1-</u> Year <u>62</u>   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Col.</u>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>1892</u>                                       |
| 9. AGE (last birthday)<br><u>Abt. 70</u>   |   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HR<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Columbus, Miss.</u>  |
| 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |   | 13a. FATHER'S NAME<br><u>Hughes Short</u>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><u>Celia Amos</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Dell Willis-339 So. Harrison</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><u>Kirkwood, Mo.</u>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>uremia</u><br>DUE TO (b) <u>chron. pyelonephritis</u><br>DUE TO (c) <u>6000</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>coronal arteriosclerosis, decub. ulcers</u><br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>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>10-29-62</u> to <u>11-1-62</u> and last saw her/him alive on <u>11-1-62</u><br>Death occurred at <u>9:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |   | 22a. SIGNATURE (Degree or title)<br><u>J. E. Smith M.D.</u>   |   |
| 22b. ADDRESS<br><u>1515 LAFAYETTE AVE.</u>   |   | 22c. DATE SIGNED<br><u>11-1-62</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  | 23b. DATE<br><u>11-8-62</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Father Dickson</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>Kirkwood, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>A.L. Beal Und. Co. 4303 Delmar</u>  |   | 25. DATE RECD. BY LOCAL REG. REGISTRAR'S SIGNATURE<br><u>NOV 5 1962</u> <u>Boad Smith, M.D.</u>   |   |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59  
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Thomas E. Brittingham, M.D.  
USE BLACK INK OR TYPEWRITER RIBBON

0-101

STATE OF ILLINOIS

of 1932

**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 Arthur L. Halliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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.