

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048261
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District 1003 Registrar's No. 12453

FILED JAN 10 1963

1. PLACE OF DEATH
a. COUNTY MISSOURI
b. CITY (If outside corporate limits, give TOWNSHIP only) ST. LOUIS MO Length of stay in 1b 39 Yrs
c. CITY OR TOWN ST. LOUIS Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 2230, A CASS AVE. Reside on Farm Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY *****
c. CITY OR TOWN ST. LOUIS Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 2230, A CASS AVE. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First MARY Middle CUMMINGS Last CUMMINGS
4. DATE OF DEATH Month DEC. Day 24, Year 1962

5. SEX FEMALE 6. COLOR OR RACE COL. 7. Married Never Married Widowed Divorced
8. DATE OF BIRTH 10/9/1890 9. AGE (last birthday) 72
IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY DOMESTICS
11. BIRTHPLACE (City and state or country) AMIT COUNTY MISSISSIPPI U.S.A
12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME PETER JEFFERSON 13b. MOTHER'S MAIDEN NAME PATIENT SPEARS 14. NAME OF HUSBAND OR WIFE PETER CUMMINGS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. ? 17. INFORMANT PETER CUMMINGS Address 2230, A. CASS AVE (Apt. 701)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism
DUE TO (b) Recent Pelvic Surgery
DUE TO (c) 631X
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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour 11:30 A Month, Day, Year 12/24/62
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 631X 20f. CITY, TOWN, OR LOCATION ST. LOUIS COUNTY ST. LOUIS STATE MISSOURI

21. I attended the deceased from 12/20/62 to 12/24/62 and last saw her/him alive on 12/24/62
Death occurred at 11:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Donald R. Jerome M.D. (Degree or title) 22b. ADDRESS 1515 LAFAYETTE AVE 22c. DATE SIGNED 12/24/62

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 12/27/62 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEMETERY 23d. LOCATION (City, town, or county) (State) ST. LOUIS. MISSOURI

FUNERAL DIRECTOR John Houston ADDRESS 12, THOMAS ST. 25. DATE RECD. BY LOCAL REG. DEC 27 1962 26. REGISTRAR'S SIGNATURE Neal Smith, M.D.

JEROME USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

Quoted by Secretary for protocol of Atlanta

VS 300 Rev. 4/59

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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

T. Coffey E. Cooper

Licensed Embalmer No. 4600

P. O. Address 4648 St. Ferdinand
St. Louis 13, Mo.

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.