

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12460-62-048353

STATE FILE NUMBER

318

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

DO NOT WRITE ON THIS STUB

AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY-AFFIDAVIT OF

ITEM NO. SHOULD READ

|   |   |   |  |   |                                  |
|---|---|---|--|---|----------------------------------|
| FILED JAN 10 1962   |   | 1. PLACE OF DEATH   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |                                  |
| a. COUNTY   |   | b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |  | a. STATE <b>Missouri</b> b. COUNTY  |                                  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>DOA Homer G. Phillips Hosp</b>  |   | Length of stay in 1b  |  | c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                                  |
| 3. NAME OF DECEASED (Type or print)   |   | 4. DATE OF DEATH  |  | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |                                  |
| First <b>Lily</b> Middle <b>Gates</b> Last  |   | Month <b>Dec.</b> Day <b>24.</b> Year <b>1962</b>   |  |   |                                  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>Negro</b>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>7-10-98</b>                                    | 9. AGE (last birthday) <b>64.</b>   | IF UNDER 1 YEAR IF UNDER 24 HR   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country) <b>Shelby, Mississippi</b> 12. CITIZEN OF WHAT COUNTRY <b>USA</b>  |                                  |
| 13a. FATHER'S NAME <b>Eddie Pringe</b>  |   | 13b. MOTHER'S MAIDEN NAME <b>Henrietta Spring</b>   |  | 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) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>Unknown</b>  |  | 17. INFORMANT <b>Martha House</b> Address <b>3957a Cook Ave.</b>  |                                  |
| 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) <b>Cyst Adenoma of Ovary with Metastasis to the liver and regional lymph nodes.</b>   |   |   |  |   |                                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |   |   |  |   |                                  |
| DUE TO (b) <b>175.0</b>   |   |   |  |   |                                  |
| DUE TO (c)  |   |   |  |   |                                  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown |                                  |
| 19. WAS AUTOPSY PERFORMED? 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 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 _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |                                  |
| 22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>9<sup>th</sup> A</b>   |   | 22b. ADDRESS <b>1300 Clark</b>  |  | 22c. DATE SIGNED <b>12-27-62</b> (State)  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  | 23b. DATE <b>12-29-62</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson Cemetery</b>   | 23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b> |   |                                  |
| 24. FUNERAL DIRECTOR <b>G. Wade Granberry</b> ADDRESS <b>4202 Finney Ave.</b>   |   | 25. DATE RECD. BY LOCAL REG. <b>DEC 27 1962</b>   | REGISTRAR'S SIGNATURE <i>[Signature]</i> <b>Roan Smith, M.D.</b>   |   |                                  |

USE BLACK INK OR TYPEWRITER RIBBON

**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 Edward A. Finney

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.,  
St. Louis, 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.