

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

12295-62-048547
STATE FILE NUMBER

318

1003

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED JAN 2 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY St. Louis		Length of stay in 1b 4 5 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4309 Laclede		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 4309 Laclede		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last STANLEY F. McCLINTOCK				4. DATE OF DEATH Month Day Year Dec. 19, 1962		5. SEX Male		6. COLOR OR RACE White	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5/4/10		9. AGE (last birthday) 52		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Black & White		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Robert E. McClintock			13b. MOTHER'S MAIDEN NAME Mada McClintock			14. NAME OF HUSBAND OR WIFE Lucille			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO.		17. INFORMANT Address Lucille McClintock, 4309 Laclede				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction and Congestive heart failure DUE TO (b) ASAO 420.0 DUE TO (c) ASAO 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH
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 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 Oct '62 to Dec 19 '62 and last saw her alive on Dec 19 '62 Death occurred at 1:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Gynn Wayman Alder M.D. (Degree or title)				22b. ADDRESS ST. LUKES HOSPITAL ST. LOUIS		22c. DATE SIGNED 12-21-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12/22/62		23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)	
24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette ADDRESS				25. DATE OF DEATH DEC 22 1962		26. REGISTRAR'S SIGNATURE Roald Smith, M.D.			

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 A. G. Ferris

Licensed Embalmer No. 3384

P. O. Address St. Louis

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.