

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-048554
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11952**

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 21 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
St. Louis		St. Louis		13 days		Illinois		Edwards		Albion		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION						Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
St. Louis Children's Hospital						Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		32 Wilson Street				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last						4. DATE OF DEATH Month Day Year									
Tina Louise McKibben						12-12-62									
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
F		W				9-17-61		14 mos.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY			
none				none				Fairfield, Ill.				U.S.A.			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
Daniel J. McKibben				Phyllis Aldridge				None							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INTERMEDIATE ADDRESS							
no				none				E. Worthington St. Louis 500 S. Kingshighway 10, Mo.							
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) <i>Cardiac Failure</i>															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.															
DUE TO (b) <i>Tetralogy of Fallot</i>															
DUE TO (c) <i>754.0</i>															
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.					
<i>Hemiparesis</i>										<input type="checkbox"/> Yes <input checked="" 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 <u>11-29-62</u> to <u>12-12-62</u> and last saw her/him alive on <u>12-12-62</u> Death occurred at <u>1:42p</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <i>Edward T. Barkus M.D.</i>						22b. ADDRESS <i>500 S. Kingshighway</i>			22c. DATE SIGNED <i>12/12/62</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-15-62		23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery			23d. LOCATION (City, town, or county) Albion, Illinois		(State)					
24. FUNERAL DIRECTOR C. R. Nale, Albion, Ill.						25. DATE RECD. BY LOCAL REG. DEC 13 1962		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>							

USE BLACK INK OR TYPEWRITER RIBBON

REVISED 1957

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 Not Embalmed Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Kessly III

Licensed Embalmer No. 5039

P. O. Address Ed Lewis III

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.