

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048790

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **12166**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 2 1962

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| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT |
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| | MEDICAL CERTIFICATION | BY AFFIDAVIT OF | | |
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|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY - | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY - | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homey Phillips | | d. STREET ADDRESS (If outside, give location) 5336 Northland | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Albert Middle Tate Last Tate | | 4. DATE OF DEATH Month 12 - Day 16 - Year 62 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-3-1886 |
| 9. AGE (last birthday) 76 | | 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) LABOR | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (City and state or country) Lexington, Miss | | 12. CITIZEN OF WHAT COUNTRY America | |
| 13a. FATHER'S NAME Mark Tate | | 13b. MOTHER'S MAIDEN NAME Clara Johnson | |
| 14. NAME OF HUSBAND OR WIFE GRACE TATE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 4201 | |
| 17. INFORMANT Lewis V. Young | | Address 5336 Northland | |
| 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 INFARCT | | | INTERVAL BETWEEN ONSET AND DEATH 8 hours |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4201 | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Vascular Accident | | | 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 checked="" type="checkbox"/> NO <input 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. | 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 1959 to Dec. 16, 1962 and last saw her him alive on Dec. 16, 1962 | | Death occurred at 9:20 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE Lewis J. Young M.D. (Degree or title) | | 22b. ADDRESS 5805 Easton Ave. | |
| 22c. DATE SIGNED 12/17/62 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 12/21/62 | 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PK CEM. | |
| 23d. LOCATION (City, town, or county) ST. LOUIS COUNTY | | (State) MO | |
| 24. FUNERAL DIRECTOR THOMAS JACKSON ADDRESS 2741 DICKSON | | 25. DATE RECD. BY LOCAL REG. DEC 18 1962 | |
| 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | | |

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

Leroy W. Bonniester

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.