

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048001

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3774 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Manchester		Length of stay in 1b 9 yrs	c. CITY OR TOWN Robertson
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pine Crest Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 552 Laurel Lane
3. NAME OF DECEASED (Type or print) First Arthur Middle Glen Last Hicks		4. DATE OF DEATH Month 12 Day 21 Year 1962	
5. SEX Male	6. COLOR OR RACE Colored	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-3 1891
9. AGE (last birthday) 71		IF UNDER 1 YEAR Months 9 Days 18	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Brownsville, Tenn.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. NAME OF HUSBAND OR WIFE	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
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.	
17. INFORMANT Ozie Hudson		Address 552 Laurel Lane, Robertson, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arterio-sclerotic Cardio-Vascular Disease & Chronic Brain Syndrome DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I Arterio-sclerotic Heart Disease			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.) NONE	
20c. TIME OF INJURY Hour Month, Day, Year 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.) 8-25-62	
20f. CITY, TOWN, OR LOCATION 12-21-62			
20g. COUNTY 12-13-62			
20h. STATE			
21. I attended the deceased from 8-25-62 to 12-21-62 and last saw him alive on 12-13-62 Death occurred at 240 P on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Allen A. Kearney M.D.		22b. ADDRESS 860 N. Woodlawn	
22c. DATE SIGNED 12-22-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-24-1962	
23c. NAME OF CEMETERY OR CREMATORY Father Dickson		23d. LOCATION (City, town, or county) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Jas. H. Randle & Son		25. DATE RECD. BY LOCAL REG. 12-24-62	
ADDRESS 3133 Bell Ave.		26. REGISTRAR'S SIGNATURE John B. Murphy M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

SC01 (FINAL COPY) 1979

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

JAS. H. RANDLE & SON

Signed *Jas H Randle*

Licensed Embalmer No. *Not Embalmed*

P. O. Address _____

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.