

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

775 -63-003184  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 775

**FILED JAN 31 1963**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. 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		c. CITY OR TOWN		Inside Limits				
		<b>St. Louis</b>				<b>St. Louis</b>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS (If outside, give location)						
<b>Homer G. Phillips</b>				Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>5414 Cote Brilliante</b>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH			
			<b>Eva</b>		<b>Gray</b>		<b>Bailey</b>		Month <b>1</b> Day <b>23</b> Year <b>63</b>			
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
<b>Fem.</b>		<b>Negro</b>				<b>5-3-1897</b>		<b>65</b>		<b>at home</b>		
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		
								<b>Wolf Island, Mo.</b>		<b>U.S.A.</b>		
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE				
<b>Van Gray</b>				<b>Mary Fletcher</b>				<b>William Bailey</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address						
<b>no</b>						<b>Thessa Hilliard Charleston, Mo.</b>						
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a)										<b>Undet.</b>		
<b>Azotemia</b>												
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (b)		DUE TO (c)						
				<b>Obstructive Uropathy</b>		<b>609x</b>						
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 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		Month, Day, Year								
		s.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		
						<b>1-22-63 2:28PM</b>		<b>1-23-63</b>		<b>1-23-63</b>		
21. I attended the deceased from <b>1-22-63 2:28PM</b> to <b>1-23-63</b> and last saw <b>him</b> alive on <b>1-23-63</b>												
Death occurred at <b>11:30 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED			
<b>B. Proffitt M.D.</b>						<b>2601 N. Whittier</b>			<b>1-24-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)				
<b>removal</b>			<b>1-24-63</b>		<b>Oak Grove Cemetery</b>			<b>Charleston, Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE						
<b>L.R. Sparks, Charleston, Mo.</b>				<b>JAN 24 1963</b>		<b>Loan Smith, M.D.</b>						

USE BLACK INK OR TYPEWRITER RIBBON

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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.

*This body not embalmed*

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Edward W. Ruffin

Licensed Embalmer No. 5022

P. O. Address Caro, Ill.

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.

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