MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-003231

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1046

FILED FEB 8 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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2 220
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2713 Madison
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Rosie Middle: Last: Blake

4. DATE OF DEATH: Month 1 Day 30 Year 63

5. SEX: Fem.
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 7-3-1905
9. AGE (last birthday): 57
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): House wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Anniston, Ala.
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: George Chambers
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Willie M. Blake

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of servi
16. SOCIAL SECURITY NO.:
17. INFORMANT: Willie M. Blake Address: 2713 Madison

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 491x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Left Cerebral Thrombosis, Rt. Hemiplegia & Multiple Decubiti

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10-4-62 to 1-30-63 and last saw him/her alive on 1-30-63
Death occurred at 4:25 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. H. Tilley MD
22b. ADDRESS: 2601 N. Whittier
22c. DATE SIGNED: 1-31-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-4-63
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cem.
23d. LOCATION (City, town, or county): St. Louis, Co. (State): Mo.

24. FUNERAL DIRECTOR: Peoples Und. Co. ADDRESS: 3100 Franklin
25. DATE RECD. BY LOCAL REG.: JAN 31 1963
26. REGISTRAR'S SIGNATURE: Joad 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_____ Signed W. Claude Gaudon
Signature of Student Embalmer

Licensed Embalmer No. 3489

P. O. Address 4500 Hamburg, Lorance

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.