

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004125

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 150

STATE FILE NUMBER

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. ~~DECLARED~~ JAN 17 1963
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN *St. Louis* Length of stay in lb *3 m.*
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION *D O A Home Health* Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) *4868 Suburban Ave* Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE *MO* b. COUNTY

3. NAME OF DECEASED (Type or print) First *Debra* Middle *Smith* Last
 4. DATE OF DEATH Month *1* Day *5* Year *63*

5. SEX *F* 6. COLOR OR RACE *W* 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH *10-3-1962* 9. AGE (last birthday) *3 months* IF UNDER 1 YEAR: Months *3* Days *0* IF UNDER 24 HR: Hours *0* Min. *0*

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) *St. Louis, Mo* 12. CITIZEN OF WHAT COUNTRY *USA*

13a. FATHER'S NAME *Charlie William* 13b. MOTHER'S MAIDEN NAME *Mary Smith* 14. NAME OF HUSBAND OR WIFE *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. [redacted] 17. INFORMANT *Mary Smith* Address *4868 Suburban Ave*

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY)
 IMMEDIATE CAUSE (a) *Acute Interstitial Pneumonia*
 DUE TO (b) *(no plastic material involved)*
 DUE TO (c) *492x*
 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. 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 *8:15* a.m. *0* 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 *St. Louis* COUNTY *St. Louis* STATE *MO*

21. I attended the deceased from *8:15 A* to *8:15 A* and last saw her alive on *1-7-63*
 Death occurred at *8:15 A* m on *5* the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE *Joseph D. Quinn* (Degree or title) 22b. ADDRESS *1300 Clark* 22c. DATE SIGNED *1-7-63*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Removal* 23b. DATE *1-8-63* 23c. NAME OF CEMETERY OR CREMATORY *Father Dickson* 23d. LOCATION (City, town, or county) (State) *St. Louis Co. Mo.*

24. FUNERAL DIRECTOR *A.H. Burkes* ADDRESS *3901 Ashland* 25. DATE RECD. BY LOCAL REG. *JAN 7 1963* 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 *[Signature]*

Licensed Embalmer No. 4628

P. O. Address 1238 W. Kensington

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.