

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004346

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1180

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

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis 18, Missouri</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis 18, Missouri</b>		Inside Limits. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF DECEASED (If in hospital or institution) <b>Cardinal Glennon Hospital For Children</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3324 Missouri</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Janet</b> Middle <b>T</b> Last <b>Young</b>			4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1963</b>			5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>			
8. DATE OF BIRTH <b>12-28-60</b>		9. AGE (last birthday) <b>2 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (City and state or country) <b>Missouri</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13a. FATHER'S NAME <b>Cardell T</b>		13b. MOTHER'S MAIDEN NAME <b>Dolores C (Krahn)</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Cardell Young 3326 A Missouri Ave</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal shut down (urine)</b> DUE TO (b) <b>Possible Acute Glomerulonephritis</b> DUE TO (c) <b>590+</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>6 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Interoctitis</b>								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 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 <b>2/1/63</b> to <b>2/3/63</b> and last saw her alive on <b>2/3/63</b> Death occurred at <b>4:20 pm 2/3/63</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Thomas A. Helms, M.D.</b>						22b. ADDRESS <b>Cardinal Glennon Hospital</b>			22c. DATE SIGNED <b>2/3/63</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2/5/63</b>		23c. NAME OF CEMETERY, OR CREMATORY <b>Park Lawn Cemetery</b>		23d. LOCATION (City, town, or county) <b>Lemay Missouri</b>		(State)					
24. FUNERAL DIRECTOR <b>Moydell Funeral Home 1926 Allen</b>				ADDRESS		25. DATE RECD. BY REG. <b>FEB 4 1963</b>		26. REGISTRAR'S SIGNATURE <b>Boad Smith, M.D.</b>					

USE BLACK INK OR TYPEWRITER RIBBON

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1255-0

FILED FEB 8 1963

**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

*Hedley J. Speller*

Licensed Embalmer No.

*4950*

P. O. Address

*St Louis*

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.