

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-018096**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3839**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED APR 17 1963**

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
1								
2 <b>223</b>								
3								
4 <b>0</b>								
5 <b>0</b>								
6								
7 <b>0</b>								
8 <b>2</b>								
9								
10								
11								
12 <b>75-0</b>								
13								
<b>75</b>								

KHA TOON  
 USE BLACK INK  
 OR  
 TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b>		d. STREET ADDRESS (If outside, give location) <b>708 Ann Avenue</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BABY MALE PRESCOTT</b>		4. DATE OF DEATH Month Day Year <b>APRIL 3, 1963</b>	
5. SEX <b>Male</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>4/3/1963</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
13a. FATHER'S NAME <b>James Prescott</b>		13b. MOTHER'S MAIDEN NAME <b>Beatrice Buchanan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		17. INFORMANT Address <b>James Prescott 708 Ann, St. Louis, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY</b> DUE TO (b) <b>CONGENITAL ATELECTASIS</b> DUE TO (c) <b>762.5</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 a.m. p.m. Month, Day, Year	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>4/3/63</b> to <b>4/3/63</b> and last saw her/him alive on <b>4/3/63</b> Death occurred at <b>12:05 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE</b>	
22c. DATE SIGNED <b>4/3/63.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 4, 1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthew Sematery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>C. Hoffmeister Mortuaries</b> <b>781 1/2 So. Broadway St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 4 1963</b>	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i> <b>Roan Smith, M.D.</b>			

**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

*Louis E. Hoffmann*

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.