

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-018371

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3948**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 17 1963

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 St. Louis, Missouri		Length of stay in 1b		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 <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5065 Waterman				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First William Middle R. Last White			4. DATE OF DEATH Month April Day 6 Year 1963			5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/7/1887		9. AGE (last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 Hrs					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Novelty Co.				11. BIRTHPLACE (City and state or country) Nashville, Ark.				12. CITIZEN OF WHAT COUNTRY U.S.											
13a. FATHER'S NAME Ezekial J. White				13b. MOTHER'S MAIDEN NAME Isabella Leslie				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). Yes WW I				16. SOCIAL SECURITY NO.				17. INFORMANT Address Joseph B. White, 2622 Rock Island Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic heart disease										INTERVAL BETWEEN ONSET AND DEATH ? 6 mos													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)																							
DUE TO (c) 4200																							
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 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 October 1962 to April 6, 1963 and last saw him alive on 4-6-63 Death occurred at April 6, 1963 3:50 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE <i>Paul Maxwell</i>						(Degree or title) M.D.		22b. ADDRESS BARNES HOSPITAL 4500 Olive Street				22c. DATE SIGNED 4-8-63											
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE 4-10-63		23c. NAME OF CEMETERY OR CREMATORY National Cemetery				23d. LOCATION (City, town, or county) Jefferson Barracks, Mo.													
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.						ADDRESS		25. DATE RECD. BY LOCAL REG. APR 8 1963		26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>													

USE BLACK INK OR TYPEWRITER RIBBON

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2/29

LATINUM FORUM

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 J. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address W. Louisiana

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.