

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021247

DO NOT WRITE ON THIS STUB
 AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5320** STATE FILE NUMBER

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

FILED MAY 27 1963			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	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 Homer G. Phillips		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2714 Gamble Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Minerva Middle Addison Last		4. DATE OF DEATH Month 5 Day 15 Year 63	
5. SEX Fem.	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug 7, 1897
9. AGE (last birthday) 65		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Lake P. Louisiana
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Joseph Washington	
13b. MOTHER'S MAIDEN NAME Ellen Griffin		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No		17. INFORMANT Address Ledora Lee 2714 Gamble	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Severe Malnutrition			Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Brain Syndrome			
DUE TO (c) General Arteriosclerosis			
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"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			
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 5-3-63 to 5-15-63 and last saw live on 5-15-63 Death occurred at 4:50 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. H. Whittier</i> (Degree or title)		22b. ADDRESS 2601 N. Whittier	
		22c. DATE SIGNED 5-16-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 21, 1963	
23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
24. FUNERAL DIRECTOR ADDRESS A. B. Kosna 1221 N. Grand Blvd.		25. DATE RECD. BY LOCAL REG. MAY 17 1963	
26. REGISTRAR'S SIGNATURE <i>Coan Smith: M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

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STATEMENT BY LICENSED EMBALMER

Health

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 Oliver E Crumble

82-11-5

XX

82-11-5

82-11-5

Licensed Embalmer No. 5185

P. O. Address 1221 N Grand

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.