

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030022

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7341** STATE FILE NUMBER

FILED JUL 19 1963

DO NOT WRITE ON THIS STUB

AMENDED

| | | | |
|---------------------|--------------|--|----------|
| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF | DOCUMENT |
| 1 | | | |
| 2 <i>2109</i> | | | |
| 3 | | | |
| 4 <i>2</i> | | | |
| 5 <i>0</i> | | | |
| 6 | | | |
| 7 <i>1</i> | | | |
| 8 <i>1</i> | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 <i>77-0</i> | | | |
| 13 | | | |
| 77 | SHOULD READ | BY AFFIDAVIT OF | |
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|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Missouri | | 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 | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b 1 YRS | | 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 | | d. STREET ADDRESS (If outside, give location) 3929 Greer | |
| 3. NAME OF DECEASED (Type or print) First Arthur Middle Last Heard | | 4. DATE OF DEATH Month 7 Day 14 Year 63 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6-6-1960 |
| 9. AGE (last birthday) 3 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | 11. BIRTHPLACE (City and state or country) SARDIS MISS |
| 12. CITIZEN OF WHAT COUNTRY U.S.A | | 13. FATHER'S NAME Hosea Heard | |
| 14. MOTHER'S MAIDEN NAME 1206a Heard | | 15. NAME OF HUSBAND OR WIFE NONE | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year dates of service) NO | | 17. SOCIAL SECURITY NO. NO | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Biliary Peritonitis | | INTERVAL BETWEEN ONSET AND DEATH Undet. | |
| DUE TO (b) Opening in Duodenum | | | |
| DUE TO (c) 756.2 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) L. hydropneumothorax + non functioning R. kidney | | 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 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. 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 7-8-63 to 7-14-63 and last saw him alive on 7-14-63 Death occurred at 6:12 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Paul J. White, M.D. (Degree of Physician) | | 22b. ADDRESS 2601 N. Whittier | 22c. DATE SIGNED 7-16-63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 7-17-63 | 23c. NAME OF CEMETERY OR CREMATORY OAK Dale | 23d. LOCATION (City, town, or county) (State) Lemay MO |
| 24. FUNERAL DIRECTOR PRICE FUNERAL Home 2829 Washington ADDRESS | | 25. DATE RECD. BY LOCAL REG. JUL 16 1963 | 26. REGISTRAR'S SIGNATURE Paul Smith, M.D. |

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

Edward A. Flynn

Licensed Embalmer No.

4444

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.