

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030644

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8149**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300
Rev. 4/59

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2 *2/59*
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DATE AMENDED

INSTEAD OF

SHOULD READ

FILED AUG 15 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hosp.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3636 Gasconade				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John R. Whitener						4. DATE OF DEATH Month Day Year Aug. 9, 1963					
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1880		9. AGE (last birthday) 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Assembler				10b. KIND OF BUSINESS OR INDUSTRY Century Electric Co.		11. BIRTHPLACE (City and state or country) Mo.		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Joseph H. Whitener				13b. MOTHER'S MAIDEN NAME Frances Tucker				14. NAME OF HUSBAND OR WIFE Lula Whitener			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no						16. SOCIAL SECURITY NO.		17. INFORMANT Address Lula Whitener 3636 Gasconade, St. Louis, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage										INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ASHD 443X											
DUE TO (c) HCV D											
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 July 1 1963 to Aug 9 1963 and last saw her alive on Aug 9 1963 Death occurred at 6:15 P 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) M.D.						22b. ADDRESS 40755 Grand			22c. DATE SIGNED 8/10/63		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-12-63		23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park			23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.				
24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.						25. DATE RECD. BY LOCAL REG. AUG 10 1963		26. REGISTRAR'S SIGNATURE <i>[Signature]</i> Coal Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Wm. D.

Kienye

6200 Lorain

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

James C. Hill

Licensed Embalmer No. *4347*

P. O. Address

6322 So 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.