

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-034185**

Registration District No. **318**

Primary Registration District **1003**

Registrar's No. **8320**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 22 1963**

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <b>22</b>				
3				
4 <b>1</b>				
5 <b>0</b>				
6				
7 <b>1</b>				
8 <b>1</b>				
9				
10				
11				
12 <b>75-0</b>				
13				
<b>75</b>	SHOULD READ	BY AFFIDAVIT OF	MEDICAL CERTIFICATION	ITEM NO.

PHILLIS  
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, MO.</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>3 1/2 Yrs.</b>		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>1522 B. Lafayette</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) <b>MABLE USREY</b>			4. DATE OF DEATH Month <b>8</b> Day <b>14</b> Year <b>63</b>
5. SEX <b>Female</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>9/15/99</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>
13a. FATHER'S NAME <b>Andrew J. Usrey</b>		13b. MOTHER'S MAIDEN NAME <b>India E. Sutherland</b>	14. NAME OF HUSBAND OR WIFE <b>None.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT Address <b>Vergil Usrey, Rt. 2, Coulterville, Ill.</b>	
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) <b>Bronchopneumonia</b>			
DUE TO (b) <b>Chronic Lymphocytic Leukemia</b>			
DUE TO (c) <b>204.0</b>			
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 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 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>8/12/63</b> to <b>8/14/63</b> and last saw her alive on <b>8/14/63</b> Death occurred at <b>8:46 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Richard L. Phillis M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22c. DATE SIGNED <b>8/14/63</b>		22d. LOCATION (City, town, or county) <b>Marion, Ill.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/16/63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		23d. LOCATION (City, town, or county) <b>Marion, Ill.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>McLaughlin, 2301 Lafayette, St. Louis 4, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 15 1963</b>	
26. REGISTRAR'S SIGNATURE <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

Licensed Embalmer No. 550

P. O. Address St. Louis, Mo

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.