

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9693 63-032757
STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 4 1963

VS 300 Rev. 4/59
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
5. SEX Male Female		6. COLOR OR RACE Negro White	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Oct 31 1910	
9. AGE (last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser	
11. BIRTHPLACE (City and state or country) Ballground, Miss.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME John Lattimore		13b. MOTHER'S MAIDEN NAME Fannie Miller	
14. NAME OF HUSBAND OR WIFE Magnolia Lattimore		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No	
16. SOCIAL SECURITY NO. 581.0		17. INFORMANT Margaret Smith 4766 Northland Ave	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute exsanguination, contib.</i> DUE TO (b) <i>Airhoasis of liver with ruptured</i> DUE TO (c) <i>esophagus and esophageal varix</i> 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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>[Signature]</i>		22b. ADDRESS 1300 Clack	
22c. DATE SIGNED 9-26-63		23. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Oct. 1, 1963	
23c. LOCATION (City, town, or county) St. Louis County		23d. STATE Mo	
24. FUNERAL DIRECTOR <i>[Signature]</i> 1221 N. Grand Blvd.		25. DATE RECD. BY LOCAL REG. SEP 28 1963	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE BLACK INK OR TYPEWRITER RIBBON

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

Oliver Crumble

Licensed Embalmer No. 5185

P. O. Address 1221 N Grand Ave

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.