

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038050

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9440**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 4 1963

VS 300 Rev. 4/59	DATE AMENDED
1	
2 21/1	
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12 91	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4227 A Aldine Avenue	
3. NAME OF DECEASED (Type or print) First Mary Middle Smith Last		4. DATE OF DEATH Month 9 Day 19 Year 1963	
5. SEX Female	6. COLOR OR RACE Colored	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1904
9. AGE (last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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) Mississippi
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. NAME OF HUSBAND OR WIFE Deceased	
13a. FATHER'S NAME General Booker		13b. MOTHER'S MAIDEN NAME Louise Ivy	
14. NAME OF DECEASED General Booker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Effie Clayhorn-5915 South Union	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arterio Sclerosis DUE TO (c) 331 X		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	
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 checked="" 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 Month, Day, Year p.m.		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 _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 9/20/63		22d. LOCATION (City, town, or county) (State) Chicago, Illinois	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal		23b. DATE 9-23-1960	
23c. NAME OF CEMETERY OR CREMATORY Restville Cemetery		23d. LOCATION (City, town, or county) Chicago, Illinois	
24. FUNERAL DIRECTOR Ellis Funeral Home-2820 Stoddard St.		25. DATE RECD. BY LOCAL REG. SEP 20 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

Fulton E. Reiter

Licensed Embalmer No. 498

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.