

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

■63-045306

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11518

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 12 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>11 1/2 hrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital #1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>1309A North Kingshighway</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A.</u> Last <u>Cayce</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1963</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1904</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Allen & Supreme Cab. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Farmington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Gus Cayce</u>		13b. MOTHER'S MAIDEN NAME <u>Annie (unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Martha Cayce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of no)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Martha Cayce 1309A North Kingshighway</u> Address <u>Wife</u>			
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, due to perforation of appendix (non-traumatic)</u>		DUE TO (b) <u>5501</u>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		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 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 <u>9:30 P</u> to <u>1300</u> and last saw her/him alive on <u>11-21-63</u> . Death occurred at <u>City</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
21a. SIGNATURE <u>Joseph M. Cozian</u> (Degree or title)		21b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>11-21-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-23-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City</u>		23d. LOCATION (City, town, or county) (State) <u>Farmington, Mo.</u>	
24. FUNERAL DIRECTOR <u>Cozian Funeral Home Farmington, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>NOV 21 1963</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>			

USE BLACK INK OR TYPEWRITER RIBBON

NOV 11 1968

STATE

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 L. Curson

Licensed Embalmer No. 5168

P. O. Address Millstadt, Illinois

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.