

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045961

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11516**

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC - 2 - 1963

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <i>21/18</i>				
3				
4 <i>3</i>				
5 <i>2</i>				
6				
7 <i>1</i>				
8 <i>1</i>				
9				
10				
11				
12 <i>77-0</i>				
13				
<i>77</i>	SHOULD READ	BY AFFIDAVIT OF		

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		Length of stay in 1b	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 Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1714 Wagoner Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Frankie Rodgers		First Frankie Middle Rodgers Last	4. DATE OF DEATH Month 11 Day 19 Year 63
5. SEX Fem.	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/10/1904
9. AGE (last birthday) 59		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	12. BIRTHPLACE (City and state or country) <i>Miss</i>
13. CITIZEN OF WHAT COUNTRY <i>U.S.</i>		13a. FATHER'S NAME <i>John Eleby</i>	13b. MOTHER'S MAIDEN NAME <i>Louise West</i>
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, unknown) (If yes, give dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Rose Felton 5600 Gates</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus			INTERVAL BETWEEN ONSET AND DEATH Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 465X			
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 _____ 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 10-7-63 to 11-19-63 and last saw him alive on 11-19-63 Death occurred at 7:10 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Andrew D. Spencer M.D.</i>		22b. ADDRESS 2601 N. Whittier	22c. DATE SIGNED 11-19-63
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE 25/10/63	23c. NAME OF CEMETERY OR CREMATION <i>Washington Park</i>	23d. LOCATION (City, town, or county) (State) <i>St Louis Co Mo</i>
24. FUNERAL DIRECTOR <i>Leonard C. Davis Funeral Home</i>		ADDRESS <i>13590 Union</i>	25. DATE RECD. BY LOCAL REG. NOV 21 1963
			26. REGISTRAR'S SIGNATURE <i>Leod Smith. M.D.</i>

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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 A. Hyatt

Licensed Embalmer No. 4441

P. O. Address 1389 Union

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.

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