

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11341 **63-046203**
STATE FILE NUMBER

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

FILED NOV 22 1963

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4mos. 3days	c. CITY OR TOWN Murphysboro		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route # 3 Box 66	
3. NAME OF DECEASED (Type or print) First LISA Middle KAYE Last WILL			4. DATE OF DEATH Month 11 Day 15 Year 63		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-21-63	9. AGE (last birthday) 4	IF UNDER 1 YEAR Months 4 Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Carbondale, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Lavern Paul Will		13b. MOTHER'S MAIDEN NAME Dorris Pugh		14. NAME OF HUSBAND OR WIFE Single	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT St. Louis, Missouri Ann Pryor 500 So. Kingshighway	
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) RESPIRATORY ARREST					SUDDEN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CHRONIC ASPIRATION PNEUMONITIS					6 MOS
DUE TO (c) GASTRO-ESOPHAGEAL REFLUX, SEVERE					SINCE BIRTH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 756.2				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 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 _____ 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 7/12/63 to NOVEMBER 15/63 and last saw her alive on 11/15/63 Death occurred at 9:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Pammy Harwell, M.D.		(Degree or title)		22b. ADDRESS 500 So Kings Highway	22c. DATE SIGNED 11/15/63
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
Burial		11-17-63	Pleasant Grove Mem.		Murphysboro, Ill.
24. FUNERAL DIRECTOR R.A. Crawshaw, Murphysboro, Ill.			25. DATE RECD. BY LOCAL REG. NOV 16 1963	26. REGISTRAR'S SIGNATURE Roal Smith, M.D.	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

5101

818

RESPIRATORY ARREST

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. 5039

P. O. Address E St Louis Ill

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.

20-11-11 18:10