

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-046214

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11232 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

FILE NO. NOV 22 1963

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 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>3915 Kennerly</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>3915 Kennerly</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Matilda Wilson</u>						4. DATE OF DEATH Month Day Year <u>Nov 8 1963</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/29/1906</u>		9. AGE (last birthday) <u>57</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Henry Malone</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Godlach</u>				14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mary Hope 3915 Kennerly</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension & Arteriosclerosis H.O.</u>										3 yrs.	
DUE TO (c) <u>420.1</u>											
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 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 s.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>Oct. 1962</u> to <u>Nov. 8, 1963</u> and last saw her/him alive on <u>Nov. 8, 1963</u> Death occurred at <u>6:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>Ledie F. Bond M.D.</u> (Degree or title)						22b. ADDRESS <u>5805 Easton Ave.</u>			22c. DATE SIGNED <u>11/12/63</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>		23b. DATE <u>Nov 15, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holly Springs Cemetery</u>		23d. LOCATION (City, town, or county) <u>Holly Springs</u>		STATE <u>Miss.</u>			
24. FUNERAL DIRECTOR <u>E. B. Kennerly</u> ADDRESS <u>1221 N. Grand Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>NOV 13 1963</u>		26. REGISTRAR'S SIGNATURE <u>Roald Smith. M.D.</u>					

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

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NAME	AGE	SEX	RACE	RELIGION	EDUCATION	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF BURIAL	PLACE OF BURIAL	NAME OF FUNERAL HOME	NAME OF EMBALMER	ADDRESS OF EMBALMER	PHONE NO.

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 Olive E. Crumble

Licensed Embalmer No. 5185

P. O. Address 1221 N. Grand Blvd

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.

MISSISSIPPI DEPARTMENT OF HEALTH
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 1221 N. GRAND BLVD