

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049866

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11921

FILED DEC 20 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>Life</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>E/R to City Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>1436 Dolman</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First Middle Last <u>LEROY I. PULLEN</u>			Month Day Year <u>Dec. 1, 1963</u>
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>		<u>12/25/07</u>
9. AGE (last birthday)		IF UNDER 1 YEAR	
<u>55</u>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
<u>Laborer</u>		<u>Unemployed</u>	<u>St. Louis, Mo.</u>
		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
<u>William Pullen</u>		<u>Minnie Seicrest</u>	<u>None</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of serv)		16. SOCIAL SECURITY NO.	17. INFORMANT
<u>No</u>			<u>Wright Pullen, 1013a Lami, St. Louis Mo.</u>
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) <u>Myocardial infarction</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) <u>420.1</u>			
DUE TO (c)			
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 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 _____ 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 (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
<u>[Signature]</u>		<u>300 Oak ave</u>	<u>12-3-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/5/63</u>	<u>St. Matthews</u>	<u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<u>McLaughlin, 2301 Lafayette Ave.</u>		<u>DEC 3 1963</u>	<u>Road Smith. M.D.</u>
<u>St. Louis 4, Mo.</u>		(Licensed Embalmer's Statement on Reverse Side)	

DO NOT WRITE ON THIS STUB  
 AMENDED  
 VS 300 Rev. 4/59  
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
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 DOCUMENT  
 MEDICAL CERTIFICATION  
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USE BLACK INK OR TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

1-10-19

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

*Amos R. Chapman*

Licensed Embalmer No. 4550

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.