

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-050005**

DO NOT WRITE ON THIS STUB

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12762 STATE FILE NUMBER

**FILED JAN 6 1964**

VS 300  
Rev. 4/59

1  
2 2069  
3  
4 3  
5 2  
6  
7 1  
8 2  
9  
10  
11  
12 77-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

|   |  |   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                     |  | Length of stay in 1b<br><u>15 yrs</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY |  | c. CITY OR TOWN<br><u>St. Louis</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><u>Homer G. Phillips</u>  |  |   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS (If outside, give location)<br><u>5707 Greer Ave.</u>   |  |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Martha</u> Middle <u>Stokes</u> Last <u>Stokes</u>  |  |   |  |   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>20</u> Year <u>63</u>  |  |   |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>Negro</u>  |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>4-4-1886</u>   |  | 9. AGE (last birthday)<br><u>77</u>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>Mississippi</u>  |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |  |   |  |
| 13a. FATHER'S NAME<br><u>Unknown</u>  |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |   |  | 14. NAME OF HUSBAND OR WIFE<br><u>deceased</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>No</u>  |  | 17. INFORMANT<br>Address<br><u>Carine Washington 5138 Pidge</u>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>   |  |   |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Undet.</u>                                     |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |   |  | DUE TO (b) <u>Cerebral Thrombosis</u>   |  | DUE TO (c) <u>Cerebral Arteriosclerosis</u>   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>332x</u>  |  |   |  |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>12-13-63</u> to <u>12-20-63</u> and last saw her <u>live on</u> <u>12-20-63</u><br>Death occurred at <u>6:40 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><u>[Signature]</u> (Degree or title)  |  |   |  | 22b. ADDRESS<br><u>2601 N. Whittier St.</u>   |  |   |  | 22c. DATE SIGNED<br><u>12-20-63</u> (State)   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><u>12-26-63</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Father Wilson</u>  |  | 23d. LOCATION (City, town, or county) (State)<br><u>Kirkwood Mo</u>   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>A. H. Burks 3901 Ashland</u> ADDRESS   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>DEC 24 1963</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Loan Smith, M.D.</u>  |  |   |  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

**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 *[Signature]*

Licensed Embalmer No. 4628

P. O. Address 1238 N. Campbell Street

-13-

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.