

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2581 STATE FILE NUMBER 0029625

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. ANN</u>		Length of stay in 1b <u>8 YR</u>	c. CITY OR TOWN <u>ST. ANN</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>3216 SIMS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3216 SIMS</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE W. HARGISS</u>			4. DATE OF DEATH Month Day Year <u>JULY 28 1964</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>JAN. 24, 1872</u>
9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLASS SMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>TENN.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. NAME OF HUSBAND OR WIFE <u>FANNIE ELLA HARGISS</u>	
13a. FATHER'S NAME <u>JAMES D. HARGISS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY LINVILLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>42 GLEN HARGISS 3216 SIMS, ST. ANN, MO.</u>	
17. INFORMANT Address		14. NAME OF HUSBAND OR WIFE	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion & edema</u> DUE TO (b) <u>Cardio renal let down</u> DUE TO (c) <u>Senility + prostatic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Weeks</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 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 <u>1958</u> to <u>death</u> and last saw her/him alive on <u>28 July 1964</u> Death occurred at <u>8:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul R. Whitener M.D.</u>		22b. ADDRESS <u>309 Brown Rd. St. Louis (14) MO</u>	22c. DATE SIGNED <u>29 July 1964</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>JULY 31, 1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLEN ALLEN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>GLEN ALLEN MO.</u>
24. FUNERAL DIRECTOR <u>BAKER FUNERAL Home, LUTESVILLE, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-4-64</u>	26. REGISTRAR'S SIGNATURE <u>John B. Mumfry M.D.</u>

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 Edw A Graham

Licensed Embalmer No. 5195

P. O. Address Lutesville, 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.