

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039010
STATE FILE NUMBER

AMENDED

Registration District No. 218 Primary Registration District No. 1003 Registrar's No. 9310

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4135 Finney</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>McPhan</u> Last <u>Munson</u>				4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>61</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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/5/04</u>	9. AGE (last birthday) <u>57yrs.</u>	IF UNDER 1 YEAR Months <u>8</u> Days	IF UNDER 24 HR Hours <u>5</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		
13a. FATHER'S NAME <u>James Munson</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Rabford</u>			14. NAME OF HUSBAND OR WIFE <u>Robert McPhan</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fannie Munson 4235a. E. Finney</u> Address			
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>Massive Pulmonary Embolism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____		DUE TO (c) <u>465x</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 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 <u>9-25-61</u> to <u>10-5-61</u> and last saw her <u>xxx</u> alive on <u>10-5-61</u> Death occurred at <u>5:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Charl. F. ...</u> (Degree or title)			22b. ADDRESS <u>2601 N. Whittier Street</u>			22c. DATE SIGNED <u>10-6-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10/10/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>		(State)		
24. FUNERAL DIRECTOR <u>Walton Funeral Home 2707 Stoddard St.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>OCT 9 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u>			

IF AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF *Overseer: Cause or death undetermined* DOCUMENT

MEDICAL CERTIFICATION

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Fayl

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.