

318

1003

9421

-61-039247  
STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>4226 Fairfax Ave.</b>	
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) First <b>Darryl</b> Middle Last <b>Spight</b>			4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1961</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-12-61</b>	9. AGE (last birthday) <b>3</b> Months <b>3</b> Days	IF UNDER 1 YEAR Hours <b>3</b> Min.	IF UNDER 24 HR Hours <b>3</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.,</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Leon Spight</b>	13b. MOTHER'S MAIDEN NAME <b>Ruthie Epps</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Geneva Spight</b> Address <b>4226 Fairfax Ave.</b>
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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) <b>Suffocation due to aspiration</b>		
DUE TO (b) <b>When found in crib at home on October 6<sup>th</sup> 1961</b>		
DUE TO (c) <b>(no plastic inserted)</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If none, state "None") <b>accidental</b>		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 checked="" 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.) <b>See above</b>
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20c. TIME OF INJURY Hour <b>11</b> a.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>St Louis, Mo</b>	COUNTY <b>St Louis, Mo</b>	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ <sup>130 p</sup> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Paul Simon</b>	(Degree or title) <b>Deputy Coronal</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>10/10/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-11-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.,</b>
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24. FUNERAL DIRECTOR <b>G. Wade Granberry</b> ADDRESS <b>4202 Finney Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 11 1961</b>	26. REGISTRAR'S SIGNATURE <b>Lead Smith, M.D.</b>
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STATE AMENDED

INS READ OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave..

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.