

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2310-62-008707
STATE FILE NUMBER

Registered with No. 318 Primary Registration District No. 1003 Registrar's No. 2310

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

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4644 Leduc		d. STREET ADDRESS (If outside, give location) 4644 Leduc	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK Scoby		4. DATE OF DEATH Month Day Year 2 23 62	
5. SEX M	6. COLOR OR RACE C	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-16-84 77
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (City and state or country) WILSON TENN U.S.A
13a. FATHER'S NAME BERRY Scoby		13b. MOTHER'S MAIDEN NAME Millie Smith	14. NAME OF HUSBAND OR WIFE Addie Scoby
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 Address Addie Scoby 4644 Leduc
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema silicosis DUE TO (b) Silicosis DUE TO (c) 523.0 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			INTERVAL BETWEEN ONSET AND DEATH
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 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 - Feb 1, 62, to Feb 23, 1962 and last saw her/him alive on Feb 23, 1962 Death occurred at 11 A.M. 11- a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Walter A. Young (Degree or title) M.D.		22b. ADDRESS 4635 Easton	22c. DATE SIGNED 2-26-62
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-2-62	23c. NAME OF CEMETERY OR CREMATORY Greenwood	23d. LOCATION (City, town, or county) (State) 6500 St Louis AK MO.
24. FUNERAL DIRECTOR ADDRESS WALTER 2707 Stoddard		25. DATE RECD. BY LOCAL REG. FEB 27 1962	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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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. Taylor

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.