

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013032

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2856

1. PLACE OF DEATH a. COUNTY <u>MO</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MO</u>	
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>St Louis</u>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>D O A City Hosp Al.</u>		d. STREET ADDRESS (If outside, give location) <u>912 N. 18 St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u> Gladys</u> Middle <u> Mary</u> Last <u> Masyn</u>			4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>62</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1931</u>	9. AGE (last birthday) <u>30</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</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>
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13a. FATHER'S NAME <u>Sam Carboway</u>	13b. MOTHER'S MAIDEN NAME <u>Hattie</u>	14. NAME OF HUSBAND OR WIFE <u>Mustafa Masyn</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT <u>Mustafa Masyn 1006 N 15 St</u>
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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: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock plus Pneumothorax and stab</u>		INTERVAL BETWEEN ONSET AND DEATH
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO <u>Wound of the heart, suffered at hands of party or parties unknown</u>	in the vicinity of 1713 Franklin or or about March 9 <sup>th</sup> 1962.
	DUE TO <u>Homicide</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Homicide</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input checked="" type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>See above</u>
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>3-9-62</u>
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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.) <u>side walk 91</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo</u>	COUNTY	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at 2:55 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Helen L. Taylor Corcoran</u>	(Degree or title)	22b. ADDRESS <u>1300 Clark Ave</u>	22c. DATE SIGNED <u>3-14-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3 16 62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Park Mo</u>
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24. FUNERAL DIRECTOR <u>A. H. Burt</u>	ADDRESS <u>3901 Ashland</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 14 1962</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT  
MEDICAL CERTIFICATION  
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USE BLACK INK OR TYPEWRITER RIBBON

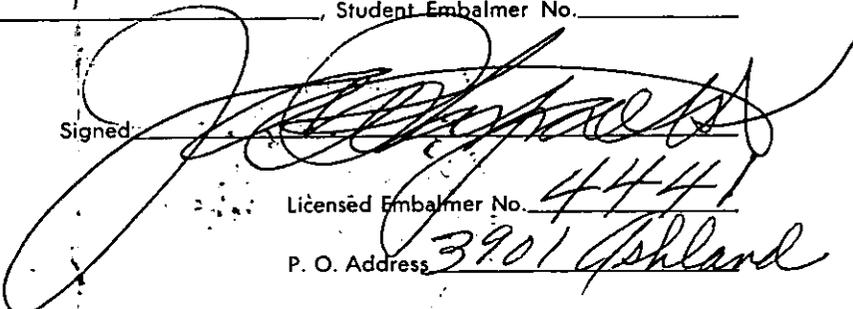
**STATEMENT BY LICENSED EMBALMER**

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:   
Licensed Embalmer No. 4441  
P. O. Address 3901 Ashland

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.