

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2843-62-013090  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2843

ED MAR 28 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 weeks</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> COUNTY <b>Madison</b>		c. CITY OR TOWN <b>Venice</b>		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>St. Mary's Infirmary</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>211 Butler Road</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DESSIE</b> Middle <b>PRATT</b> Last <b>PRATT</b>						4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1962</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/22/06</b>		9. AGE (last birthday) <b>55</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Chalktow, Miss.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>				
13a. FATHER'S NAME <b>Humphrey Townsend</b>				13b. MOTHER'S MAIDEN NAME <b>Irene Fair</b>				14. NAME OF HUSBAND OR WIFE <b>Leon Pratt</b>				
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>Unknown</b>		17. INFORMANT <b>Leon Pratt-211 Butler Rd, Venice, Ill.</b> 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) <b>Disecting Aortic Aneurism</b>										INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>		
DUE TO (b) <b>Hypertensive Arterio Vascular Disease</b>												
DUE TO (c) <b>Arteriosclerosis</b>										<b>6 months</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>451X</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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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>2-14-62</u> to <u>3-10-62</u> and last saw her <u>8 P</u> alive on <u>3-10-62</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <i>Henry C. Dugas MD</i> (Degree or title)						22b. ADDRESS <b>3136 Easton Ave.</b>			22c. DATE SIGNED <b>3-12-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3/14/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>East St. Louis, Illinois</b>						
24. FUNERAL DIRECTOR <b>Marshall Funeral Home E. St. Louis, Ill.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>MAR 14 1962</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>						

**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

*Thomas M. Robson*

Licensed Embalmer No. 4479

P. O. Address East St. Louis, Ill.

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.