

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

4298

-62-016870

STATE FILE NUMBER

DO NOT WRITE ON THIS STUDY

AMENDED
U.S. 23

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED MAY 10 1962

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

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>St. Louis</i>		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital no 1</i>		d. STREET ADDRESS (If outside, give location) <i>2932 Caroline</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Gloria Henderson</i>		4. DATE OF DEATH Month Day Year <i>April 24 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>March 16, 1908</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME <i>Caron Henderson</i>		11b. MOTHER'S MAIDEN NAME <i>Carrie Battle</i>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		12b. SOCIAL SECURITY NO.	
13a. FATHER'S NAME <i>Caron Henderson</i>		13b. MOTHER'S MAIDEN NAME <i>Carrie Battle</i>	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		14b. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Carrie Henderson</i>		18. ADDRESS <i>2932 Caroline</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Hydrocephalus.</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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
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.) <i>3:44 AM</i>	
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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Paul J. Simon</i>		22b. ADDRESS <i>1300 Clark</i>	
22c. DATE SIGNED <i>APR 25 1962</i>		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>April 26, 1962</i>		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY <i>Father Dockson St. Louis Co. Mo</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <i>A. J. Wilson 2769 Chestnut</i>		25. DATE RECD. BY LOCAL REG. <i>APR 25 1962</i>	
26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		27. ADDRESS	

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 Jefferson M. C. C. C.
Licensed Embalmer No. 5072
P. O. Address 4535 Washington

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.