

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020376

Registration District No. **318** Primary Registration District **1003** Registrar's No. **4454** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 23 1962

VS 300  
Rev. 4/59

1

2 22

3

4 3

5 0

6

7 8

8 1

9

10

11

12 92-3

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <del>ST-ROBERTS-ADO</del>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST-LOUIS-</b>		c. CITY OR TOWN <b>ST-LOUIS-</b>	
Length of stay in 1b <b>D.O.A</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HOMER PHILLIP</b>		d. STREET ADDRESS (If outside, give location) <b>2732 GAMBLE</b>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle <b>WILLIE MAY EWING MILLS</b>		4. DATE OF DEATH Month Day Year <b>4 27 62</b>	
5. SEX <b>FEMALE</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>12-19-1914</b>
9. AGE (last birthday) <b>47</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>MISSISSIPPI</b>
12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>		13a. FATHER'S NAME <b>NATHER-HICKS-</b>	
13b. MOTHER'S MAIDEN NAME <b>ALZONE HICKS-</b>		14. NAME OF HUSBAND OR WIFE <b>UNNONE</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>NONE</b>	
17. INFORMANT Address <b>MRS ANNIE MAY JOHNSON - 2259 OF OLLON</b>		18. CAUSE OF DEATH (Enter only one cause per item) PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>(Intra-Cerebral hemorrhage)</b>		DUE TO (c) <b>331x</b>	
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 checked="" type="checkbox"/> Unknown	
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 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 <b>1045 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Paul J. Simon Deputy Coroner</b>		22b. ADDRESS <b>1300 Clark</b>	
22c. DATE SIGNED <b>5/1/62</b>		23. NAME OF CEMETERY OR CREMATORY <b>FATHER DICKSON</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>5-2-62</b>	23d. LOCATION (City, town, or county) (State) <b>ST-LOUIS-COUNTY MO</b>	24. FUNERAL DIRECTOR <b>PRAYTON-FUNERAL-2649 DELMAR</b>
25. RECEIVED BY <b>MAY 1 1962</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith. M.D.</b>	

**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 Leroy W. Summister

Licensed Embalmer No. 4523

P. O. Address 4251 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.