

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020771

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4798** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAY 23 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |   | Length of stay in 1b<br><b>2 wks</b>  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>3045 R. Sheridan</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>               |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle Last <b>Moore</b>   |   | 4. DATE OF DEATH<br>Month <b>5</b> Day <b>7</b> Year <b>62</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-4-1889</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Private Family</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Winston, Mississippi</b>   |
| 13a. FATHER'S NAME<br><b>William Lobblly</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   | 17. INFORMANT Address<br><b>Lonnie Person 3045 R. Sheridan</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Undet.</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) <b>491X</b>  |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Dehydration and Malnutrition</b>  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input 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<br>Hour Month, Day, Year<br>a.m. p.m.   |   |   |   |
| 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 <b>4-16-62</b> to <b>5-7-62</b> and last saw her <input checked="" type="checkbox"/> alive on <b>5-7-62</b><br>Death occurred at <b>8:30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><i>Sydney A. Trueman, M.D.</i>  |   | 22b. ADDRESS<br><b>2601 N. Whittier Street</b>  | 22c. DATE SIGNED<br><b>5-9-62</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>14 May 1962</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Father Dicksons</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County Mo.</b>  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>E. B. Koonce 1221 N. Grand Blvd.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 10 1962</b>  | 26. REGISTRAR'S SIGNATURE<br><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

*Melvin Blackman*

Licensed Embalmer No. 3962

P. O. Address 1221 N. Grand Ave

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.