

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020927
-62-020927
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4752**

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

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4161 FARLIN AVE.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ROSIE Middle LEE Last ROSS			4. DATE OF DEATH Month MAY Day 8 Year 1962							
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-12-23	9. AGE (last birthday) 38 years	IF UNDER 1 YEAR Months 4 Days 26 Hours 26 Min.		IF UNDER 24 HR Hours 26 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) WILMONT, ARK.		12. CITIZEN OF WHAT COUNTRY U.S.A				
13a. FATHER'S NAME MOSE MORGAN			13b. MOTHER'S MAIDEN NAME ROSEANNA PORCH			14. NAME OF HUSBAND OR WIFE FREDDIE ROSS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR FREDDIE ROSS		Address 4161 FARLIN AVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE									4 WEEKS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										
DUE TO (b) BRIGHT'S DISEASE									3 YEARS	
DUE TO (c) 593x										
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 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 _____ 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 JUNE 30, 1955 to MAY 8, 1962 and last saw her/him alive on MAY 8, 1962		Death occurred at 2:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) F. R. BRADLEY, M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 5/8/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 5-14-62		23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY		23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS, MO				
24. FUNERAL DIRECTOR A.F. WALTON 2707 STODDARD ST			25. DATE RECD. BY LOCAL REG. MAY 9 1962		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.					

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 *M. C. Claude Gordon*

Licensed Embalmer No. 3489

P. O. Address 1123 N. Taylor

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.