

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024464

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6377** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 6 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. 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 ST. LOUIS CITY HOSP. #1				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 719 SOULARD				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) WILLIAM BURNETTE			First Middle Last			4. DATE OF DEATH May 29 1962			Month Day Year										
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/29/78		9. AGE (last birthday) 83		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) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) KY		12. CITIZEN OF WHAT COUNTRY U. S. A.											
13a. FATHER'S NAME GEORGE				13b. MOTHER'S MAIDEN NAME OCTAVIA				14. NAME OF HUSBAND OR WIFE											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT ST. LOUIS CITY HOSP. #1.			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) CARCINOMATOSIS SUSPECTED										INTERVAL BETWEEN ONSET AND DEATH									
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) AS4D WITH CHF										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 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.) CARCINOMATOSIS															
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 5-4-62 to 5-29-62 and last saw her alive on 5-29-62 Death occurred at 3:25 p m on the date stated above, and to the best of my knowledge, from the causes stated.						22a. SIGNATURE <i>J. E. Smith</i> (Degree or title) M. D.		22b. ADDRESS 1515 LAFAYETTE AVE.			22c. DATE SIGNED 5-29-62								
23a. BURIAL, CREMATION, REMOVAL (Specify) Rowland Aker Mortuary Service		23b. DATE 6-30-1962		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board				23d. LOCATION (City, town, or county) St. Louis, Mo. (State)											
24. FUNERAL HOME OR PLACE OF INTERMENT 4104 Manchester Ave. St. Louis 10, Mo.						25. DATE RECD. BY LOCAL REG. JUN 28 1962		26. REGISTRAR'S SIGNATURE <i>Roald 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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.