

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

7386 **62-028448**  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED AUG 6 1962**

VS 300  
Rev. 4/59

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2 *225*  
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12 *77-0*  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
		<b>St. Louis</b>		<b>3 1/2 Weeks</b>		<b>Missouri</b>				<b>St. Louis</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								Yes <input type="checkbox"/> No <input type="checkbox"/>							
		<b>Homer G. Phillips</b>										<b>1517 Inge Pl.</b>							
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH							
			<b>Ed</b>						<b>Bland</b>			Month Day Year <b>7 23 62</b>							
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR							
<b>Male</b>		<b>Negro</b>				<b>1-1-1881</b>		<b>81</b>		Months Days		Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY							
<b>Farm</b>				<b>-----</b>				<b>? Miss.</b>				<b>U. S. A</b>							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE											
<b>Unknown</b>				<b>unknown</b>				<b>Lula Bland</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address							
<b>No</b>				<b>No</b>				<b>Ben Williams</b>				<b>1611 Goddellow</b>							
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)												<b>Unknown</b>							
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 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 <b>6-26-62</b> to <b>7-23-62</b> and last saw him alive on <b>7-23-62</b> Death occurred at <b>7:10 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title)						22b. ADDRESS						22c. DATE SIGNED							
<b>Bow White MD</b>						<b>2608 N. Whittier</b>						<b>7-24-62</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)							
<b>Removal</b>		<b>July 30, 1962</b>		<b>Father Dickson</b>				<b>St. Louis County</b>				<b>Mo.</b>							
24. FUNERAL DIRECTOR						25. DATE REC'D. BY LOCAL REG.						26. REGISTRAR'S SIGNATURE							
<b>E. B. Roedel</b>						<b>JUL 27 1962</b>						<b>Roan Smith. M.D.</b>							
ADDRESS																			
<b>1221 N. Grand Blvd.</b>																			

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

**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 Milvin Blackburn

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.