

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028551
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registered on **FILED AUG 6 1962** Primary Registration District No. **1003** Registrar's No. **7527**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 40 Years	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4309 Maryland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Elmer Middle (none) Last COX			4. DATE OF DEATH Month July Day 30 Year 1962
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-2-97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Butcher	9. AGE (last birthday) 65 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) St. James, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Charles L. Cox		13b. MOTHER'S MAIDEN NAME Sarah Chilton	14. NAME OF HUSBAND OR WIFE --
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I WW II		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT William Burch 7466a Park Towne S.			Address
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Coronary Thrombosis DUE TO (c) 420.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus			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 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 1:00 a.m. p.m.	Month, Day, Year 1960	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 St. Louis	COUNTY St. Louis
21. I attended the deceased from 1960 to 7-30-62 and last saw him alive on 7-30-62 Death occurred at 1:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ann Huggins, M.D.		22b. ADDRESS 634 N. Grand	22c. DATE SIGNED 7-31-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 1, 1962	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
24. FUNERAL DIRECTOR Robert A. Donnell		ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. 8-1-1962
		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

On Albert M. Higgins
634 M. General Bldg

12:30 to 4:30 P.m.

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 *W. H. [Signature]*

Licensed Embalmer No. 4699
P. O. Address 384 [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.