

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

6816 - 62-029158
STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6816

FILED JUL 31 1962

VS 300 Rev. 4/59
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4226 3/2
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4 1
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. 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		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	Inside Limits		
St. Louis		St. Louis		2 WKS.	Missouri		Hazelwood	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits	d. STREET ADDRESS (if outside, give location)			Reside on Farm			
Cardinal Glennon Memorial Hospital for Children			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	740 Hazel Valley Dr.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH			
CYNTHIA ANN SCOGIN							Month	Day	Year	
				July	9	62				
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" 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	
Female	White		5-15-62		7-9-62		Months	Days	Hours	
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			
NONE			NONE		St. Louis Missouri		U.S.A.			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
Harry A.			Suzanne H. (Lake)			NONE				
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			
NO			NONE		HARRY SCOGIN		740 HAZEL VALLEY, HAZELWOOD, MO			
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)									10 hours	
DUE TO (b)									birth	
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.			
754.5							<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		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		July 8, 1962		to July 9, 1962		and last saw her/him alive on		July 9, 1962		
Death occurred at		7:50 P.M.		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			
Gerald F. Geisler, M.D.				3000 Lafayette			July 10, 1962			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)				
REMOVAL		7-11-1962		MEMORIAL PARK		St. Louis Co., Mo.				
24. FUNERAL DIRECTOR			ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRARS SIGNATURE			
THE FLOISSANT MORTUARY,			FLOISSANT, MO		JUL 10 1962		Joan 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 *Geord A. Hultines*

Licensed Embalmer No. 4966

P. O. Address FLORISSANT, Mo.

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.