

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032283

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7744

STATE FILE NUMBER

FILED AUG 22 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SAINT LOUIS</u>		Length of stay in 1b <u>6 YEARS</u>	c. CITY OR TOWN <u>SAINT LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ENROUTE TO CITY HOSP. #1.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3227 SAINT VINCENT AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN CLARENCE BLACK</u>			4. DATE OF DEATH Month Day Year <u>AUGUST 4, 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-'55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELEMENTARY SCHOOL</u>	9. AGE (last birthday) <u>6</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11a. BIRTHPLACE (City and state or country) <u>SAINT LOUIS, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>JOHN D. BLACK</u>		13b. MOTHER'S MAIDEN NAME <u>MARIAN GOODRICH</u>	
14. NAME OF HUSBAND OR WIFE		17. INFORMANT Address <u>MRS. MARIAN BLACK 3227 ST. VINCENT AVE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (or, or unknown)) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Tamponade as a result of a hemorrhage into the pericardial sac originating from the aorta near its origin. this was a result of a congenital defect of the aorta namely a caortation just beyond the arch.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
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 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.) <u>754.6</u>		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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>9:00 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wesley L. Taylor, Coroner</u>		22b. ADDRESS <u>1300 Clark Ave.</u>	
22c. DATE SIGNED <u>8-6-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>8-7-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NEW HAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) <u>NEW HAVEN, MISSOURI</u>	
24. FUNERAL DIRECTOR ADDRESS <u>BEIDERWIEDEN F.H. INC. 1936 ST. LOUIS AVE</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 8 1962</u>	
		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

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

Homer W. Joutz

Licensed Embalmer No. 3882

P. O. Address St Louis

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.