

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-035873

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9589 STATE FILE NUMBER

FILED OCT 11 1962

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Peoples Hospital</u> | | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>741 Walton Ave</u> | | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>A</u> Last <u>ALCORN</u> | | | | | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1962</u> | | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-1-1905</u> | | 9. AGE (last birthday) <u>57</u> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (City and state or country) <u>Grady ARK.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | | |
| 13a. FATHER'S NAME <u>Willie McDonald</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Lillie Winston</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Napoleon Alcorn</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Napoleon Alcorn - 741 Walton Ave</u> Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca. of the Breast</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Ca. of Breast</u> | | | | | | | | | | | |
| DUE TO (c) <u>170x</u> | | | | | | | | | | | |
| 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 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.) | | | | | | | |
| 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 <u>8-2-62</u> to <u>10-4-62</u> and last saw ^(her) _(him) alive on <u>10-3-62</u> Death occurred at <u>4:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>James M. Phillipino, M.D.</u> | | | | | | 22b. ADDRESS <u>2715 N. Union</u> | | | 22c. DATE SIGNED <u>10-8-62</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>10-10-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Co. Mo.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Peoples Und. Co. 3100 Franklin Ave</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>OCT 9 1962</u> | | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> | | | | | |

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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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.