

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

8984 -62-036007
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8984

FILED SEP 24 1962

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

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY _____
c. CITY OR TOWN St. Louis Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 6602 Villa Dr. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Albert Carr 4. DATE OF DEATH 9/17/62 Month Day Year

5. SEX M 6. COLOR OR RACE W 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 1/6/08 9. AGE (last birthday) 54 IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance man 10b. KIND OF BUSINESS OR INDUSTRY Water Co. 11. BIRTHPLACE (City and state or country) Phillip Miss. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME John Carr 13b. MOTHER'S MAIDEN NAME Mattie Peoples 14. NAME OF HUSBAND OR WIFE Sue Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Sue Carr, 6602 Villa Dr. Address _____

18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION < 12 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CORONARY INSUFFICIENCY
DUE TO (c) 420.1
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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 10-13-61 to 9-17-62 and last saw her alive on 9-17-62
Death occurred at 12:40 A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William R Green M.D 22b. ADDRESS 7200 Manchester, St Louis Mo 22c. DATE SIGNED 9-17-62

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 9/18/62 23c. NAME OF CEMETERY OR CREMATORY Jackson Cemetery 23d. LOCATION (City, town, or county) (State) Jackson, Miss.

24. FUNERAL DIRECTOR Rowland-Ogden Mortuary, 4106 Manchester ADDRESS _____ 25. DATE RECD. BY LOCAL REG. SEP 18 1962 26. REGISTRAR'S SIGNATURE Earl Smith M.D

USE BLACK INK OR TYPEWRITER RIBBON

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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 _____

Lawrence M. Sizemore

Licensed Embalmer No. _____

4343

P. O. Address _____

St. Louis 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.