

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036603

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registered District No. **318** Primary Registration District No. **1003** Registrar's No. **9402**  
**FILED OCT 11 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

INSTEAD OF DOCUMENT  
 Affidavit - Cause of Death - Meningitis

USE BLACK INK OR TYPEWRITER RIBBON

<b>1. PLACE OF DEATH</b> a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS (If outside, give location)					
a. COUNTY St. Louis				a. STATE Missouri					
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis				Length of stay in 1b		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 Cardinal Glennon Memorial Hospital for Children				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1414 Destrehan		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Marty Eugene Pritchett				<b>4. DATE OF DEATH</b> Month Day Year September 30-62					
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> White		<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 9-1-62		<b>9. AGE (last birthday)</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 29	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) None				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) St. Louis, Missouri		<b>12. CITIZEN OF WHAT COUNTRY</b> USA	
<b>13a. FATHER'S NAME</b> Robert L. Pritchett				<b>13b. MOTHER'S MAIDEN NAME</b> Frieda L. (Creasy)		<b>14. NAME OF HUSBAND OR WIFE</b> None			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No				<b>16. SOCIAL SECURITY NO.</b> None		<b>17. INFORMANT</b> Address Freda Pritchett, 1414 Destrehan			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalitis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <span style="float: right; font-size: 24pt;">343X</span>									
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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)				<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>	
<b>21. I attended the deceased from</b> <u>9-27-62</u> to <u>9-30-62</u> and last saw her/him alive on <u>9-30-62</u> Death occurred at <u>12:45 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
<b>22a. SIGNATURE</b> (Degree or title) Anne E. Baron, M.D.				<b>22b. ADDRESS</b> 1465 So. Grand				<b>22c. DATE SIGNED</b> 10/1/62	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Removal		<b>23b. DATE</b> 10-2-62		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Memorial Park Cemetery		<b>23d. LOCATION</b> (City, town, or county) (State) St. Louis Co., Mo			
<b>24. FUNERAL DIRECTOR</b> ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.				<b>25. DATE RECD. BY LOCAL REG.</b> OCT 1 1962		<b>26. REGISTRAR'S SIGNATURE</b> Joan Anita M.D.			

**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 Isy W Wilkins

Licensed Embalmer No. 3575

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.