

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036630

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9262

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 3 1962

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															
		<u>ST. LOUIS</u>				<u>MISSOURI</u>																	
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		Yes <input type="checkbox"/> No <input type="checkbox"/>															
<u>ST. HOMER PHILLIPS HOSP</u>		<input type="checkbox"/> No <input type="checkbox"/>		<u>3944th DELMAR</u>		Yes <input type="checkbox"/> No <input type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			Month			Day			Year		
			<u>JAMES</u>						<u>RIGNER</u>						<u>9-23-62</u>								
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR		Months		Days		Hours		Min.			
<u>MALE</u>		<u>Colored</u>				<u>3-3-93</u>		<u>69 YRS</u>		<u>6</u>													
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											
<u>LABORER</u>								<u>ST. LOUIS, MO</u>				<u>U. S. A</u>											
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
<u>UNKNOWN</u>				<u>UNKNOWN</u>				<u>UNKNOWN</u>															
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											
<u>NO</u>								<u>Celie Blodsoe</u>				<u>3944 DELMAR</u>											
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)										<u>Cerebral Vascular Disease</u>													
DUE TO (b)										<u>Arteriosclerosis</u>													
DUE TO (c)										<u>334X</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 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		Month, Day, Year		a.m.																	
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 _____ and last saw her _____ him alive on _____ Death occurred at _____ 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			
<u>Paul J. Simon</u> Deputy Coroner										<u>1300 Clark</u>										<u>9/26/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)											
<u>REMOVAL</u>		<u>9-27-62</u>		<u>GREENWOOD</u>				<u>ST. LOUIS CITY</u>				<u>MO</u>											
24. FUNERAL DIRECTOR				ADDRESS				25. DATE RECD. BY LOCAL REG.				26. REGISTRAR'S SIGNATURE											
<u>A.F. WALTON</u>				<u>2707 STODDARD</u>				<u>SEP 26 1962</u>				<u>Earl Smith, M.D.</u>											

VS 300 Rev. 4/59

1
2 219
3
4 2
5 2
6
7 0
8 2
9
10
11
12 92-3
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

91

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Taylor

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.