

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036646

8914

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District **3184** Primary Registration District **1003** Registrar's No. \_\_\_\_\_

FILED 3184 1962

VS 300  
Rev. 4/59

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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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 days</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4303 St. Louis ave.</b>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>Cleo</b> Middle Last <b>Rogers</b>		Month <b>9</b> Day <b>13</b> Year <b>62</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Homes</b>	11. BIRTHPLACE (City and state or country) <b>Bay Springs, Miss.</b>
13a. FATHER'S NAME <b>Charlie Brown</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Bridges</b>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Mary Brown 4141 Maffitt Ave.</b>
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) <b>Respiratory Failure</b>			<b>Undet.</b>
DUE TO (b) <b>Intracranial Hemorrhage</b>			
DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>			
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 checked="" type="checkbox"/> Unknown
			<b>443 X</b>
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 <b>9-10-62</b> to <b>9-13-62</b> and last saw her <b>live</b> on <b>9-13-62</b>		Death occurred at <b>4:30 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>James H. Alley, M.D.</i>		22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>9-14-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-17-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR <b>G. Wade Granberry 4202 Finney Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 15 1962</b>	26. REGISTRAR'S SIGNATURE <i>Boal Smith, M.D.</i>

**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 Edward G. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.