

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-040765
STATE FILE NUMBER

318 1003

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10199

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 1 1962

VS 300
Rev. 4/59

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DATE AMENDED
INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Maternity		d. STREET ADDRESS (If outside, give location) 5968A Cates	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Solls			4. DATE OF DEATH Month Day Year 10 13 1962
5. SEX male	6. COLOR OR RACE negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR Months Days 1 55
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Henry James Solls		13b. MOTHER'S MAIDEN NAME Sylvia Scott	
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)	
16. SOCIAL SECURITY NO.		17. INFORMANT Sylvia Solls	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure		INTERVAL BETWEEN ONSET AND DEATH 1 hr 55 min	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Prematurity			
DUE TO (c) 773.5			
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 checked="" type="checkbox"/> NO <input 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 5:35AM, 10-13-1962 to 7:30AM, 10-13-62 and last saw her/him alive on 10-13-1962 Death occurred at 7:30AM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Walter Lumbro M.D.</i> (Degree or title)		22b. ADDRESS 630 S. Kingshighway, St. Louis, Mo.	
22c. DATE SIGNED 10-19-62		23. LOCATION (City, town, or county) (State) St. Louis, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-31-1962		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR Rowland Mortuary Svc. ADDRESS 4104-06		25. DATE OF LOCAL REG. 10-13-1962	
26. REGISTRAR'S SIGNATURE <i>Walter Lumbro M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 _____

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.