

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

1003

10589-62-040807

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

FILED NOV 13 1962

VS 300
Rev. 4/59

1

2 20

3

4 0

5 1

6

7 0

8 2

9

10

11

12 63-0

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

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		Missouri COUNTY																					
St. Louis		St. Louis		7 Days		c. CITY OR TOWN		St. Louis																					
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																					
Incarnate Word Hospital		Yes <input type="checkbox"/> No <input type="checkbox"/>		316 W. Primm St.				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			Month			Day			Year								
Joseph			E.			Thomas						November			3			1962											
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR																	
Male		White				8-6-1901		61		Months		Days		Hours		Min.													
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																	
Salesman				Nursery Supplies				St. Louis, Missouri.																					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE																					
George W. Thomas				Amelia Schultheis				Marie E.																					
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																	
No								Marie E. Thomas				316 W. Primm St.																	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH																			
IMMEDIATE CAUSE (a)										2 1/2 mos																			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										163x																			
DUE TO (b)																													
DUE TO (c)																													
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																									
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 10-26-62 to 11-3-62 and last saw him alive on 11-3-62										Death occurred at 1:40 PM on the date stated above by my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title)										22b. ADDRESS										22c. DATE SIGNED									
Drennan Bailey M.D.										8356 CLAYTON ROAD										11-5-62									
										ST. LOUIS 17, MO.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				23e. (State)									
Removal										11-6-1962		Regurrection Cemetery				Watson & McKenzie Rd.													
24. FUNERAL DIRECTOR										ADDRESS		25. DATE RECD. BY LOCAL REG.				26. REGISTRAR'S SIGNATURE													
C. Hoffmeister Mortuaries										781 S. Broadway		NOV 5 1962				Earl Smith, 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 *Lewis C. Hoffmeister*

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.

*Dr. Newman Bailey, 6356 Clayton 1-6 PM
MI 7-3634*