

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044216

STATE FILE NUMBER

318

1003

10927

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED NOV 26 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

1. PLACE OF DEATH a. COUNTY St. Louis		Length of stay in 1b 3 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		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 Homer G. Phillips				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 4259 E. Kennerly			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert (Bob) Ford			4. DATE OF DEATH Nov. 10 1962			5. SEX Male		6. COLOR OR RACE Negro		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 12/12/1912		9. AGE (last birthday) 49		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY U. S. A	
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Catherine Ford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Catherine Ford 4259 E. Kennerly					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastroenteritis DUE TO (b) Intestinal obstruction DUE TO (c) 5711 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
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 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 St. Louis, County				20g. STATE Mo.			
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 12:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE Helen L. Taylor, Coroner						22b. ADDRESS 1300 Clark Ave.			22c. DATE SIGNED 11-13-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Nov. 16, 1962		23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery			23d. LOCATION (City, town, or county) St. Louis, County			23e. STATE Mo.	
24. FUNERAL DIRECTOR B. Keene				ADDRESS 1221 N. Grand Blvd.				25. DATE RECD. BY LOCAL REG. NOV 13 1962		26. REGISTRAR'S SIGNATURE Coal Smith, M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

Handwritten text, possibly a name or date, mostly illegible.

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 *Mareece Prosser*

Licensed Embalmer No. 4755
P. O. Address 1221 N. Wood

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.