

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044920

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10738** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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			
		St. Louis				Missouri					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
		Homer G. Phillips Hosp				4143 Farlan Ave.,					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH Month Day Year					
Marion Stephenson						Nov. 5, 1962					
5. SEX Female	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 4-7-1925	9. AGE (last birthday) 37	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR 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		
Domestic Work						New Orleans, Louisiana			USA		
13a. FATHER'S NAME Isaac Stephenson				13b. MOTHER'S MAIDEN NAME Susie Tillman				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. Unknown		17. INFORMANT Isaac Stephenson		Address 4143 Farlan Ave.,			
No											
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) <i>Carcinoma of Colon</i>											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b) _____											
DUE TO (c) _____										153.8	
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			
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 _____ to _____ 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 <i>Joseph M. Johnson</i>	(Degree or title) <i>Deputy</i>	22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>11-8-62</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>11-8-62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Orleans La.</i>	23d. LOCATION (City, town, or county) <i>State</i>								
24. FUNERAL DIRECTOR <i>G. Wade Granberry</i>	ADDRESS <i>4202 Finney Ave.,</i>	25. DATE RECD. BY LOCAL HEALTH OFFICER <i>NOV 8 1962</i>	REGISTRAR'S SIGNATURE <i>Boad Smith, M.D.</i>								

USE BLACK INK OR TYPEWRITER RIBBON

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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 A. 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.