

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-048204

318

1003

12668

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

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

FILED JAN 10 1963

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. # 1 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____ c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1221 1/2 6th ST. Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FESTUS Middle _____ Last BROWN		4. DATE OF DEATH Month DEC. Day 30, Year 1962	
5. SEX MALE	6. COLOR OR RACE NEGRD	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-20-1897
9. AGE (last birthday) 65		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (City, and state or country) WHITEVILLE, TENN.		12. CITIZEN OF WHAT COUNTRY U. S. A	
13a. FATHER'S NAME GIO BROWN		13b. MOTHER'S MAIDEN NAME RACHAEL KNEW	
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR I	
16. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver, Metastatic DUE TO (b) Primary site unknown DUE TO (c) 1562		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) Obstructive Jaundice		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 _____ COUNTY _____ STATE _____
21. I attended the deceased from 12-17-62 to 12-30-62 and last saw her/him alive on 12-30-62 Death occurred at 1:15 pm on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert L. Slason, M.D.</i> (Date of issue) _____		22b. ADDRESS 1515 LAFAYETTE	
22c. DATE SIGNED 12-30-62		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 1-3-1963	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY		23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACK, MO.
24. FUNERAL DIRECTOR McCLAIN ADDRESS 1841 CASS AVE.	25. DATE RECD. BY LOCAL REG. JAN 2 1963		26. REGISTRAR'S SIGNATURE <i>Robert Smith, M.D.</i>

GLASS USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59

1. _____

2. **2229**

3. _____

4. **2**

5. **0**

6. _____

7. **1**

8. **2**

9. _____

10. _____

11. _____

12. **75-0**

13. _____

75

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

Wallace R. Williams

Licensed Embalmer No. 4926

5135 Latis
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.