MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048648

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12683

FILED JAN 10 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: Life
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 5837 Highland Ave.
Inside Limits: Yes ☐ No ☐

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 ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5837 Highland
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Louis Middle: Last: Patterson
4. DATE OF DEATH: Month: I2 Day: 3I Year: 62
5. SEX: Male
6. COLOR OR RACE: Col.
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 2/28/8I
9. AGE (last birthday): 8I
IF UNDER 1 YEAR: Months: IO Days: 3
IF UNDER 24 HR: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nil
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA.
13a. FATHER'S NAME: ? Patterson
13b. MOTHER'S MAIDEN NAME: Callie ?
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: LLoyd Patterson Address: 4022 Cote Britiant

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 3 mos
DUE TO (c) 420.0
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Dec 16, 62, to Dec 31, 62 and last saw him alive on 12. 30 62
Death occurred at 7.00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Kearl Smith MD
22b. ADDRESS: 4069 Easton Ave
22c. DATE SIGNED: 1.2.63
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: I/3/63
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.
24. FUNERAL DIRECTOR: Wright's Funeral Home ADDRESS: 3I00 Easton Ave.
25. DATE RECD. BY LOCAL REG.: JAN 2 1963
26. REGISTRAR'S SIGNATURE: Kearl 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 Arthur L Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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.