

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003650

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **416**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 17 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		a. STATE Missouri b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP#1		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1701 Cole St.,	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle Last JACKSON		4. DATE OF DEATH Month 1 Day 12 Year 63	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (last birthday) Abt. 74		IF UNDER 1 YEAR IF UNDER 24 HR Months Days 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) Louisiana		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Amanda Wilson	
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) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Cham Coleman Address 5209 Kensington Ave.,	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease 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) Osteo-arthritis			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m.	
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 12-19-62 to 1-12-63		COUNTY STATE	
21. I attended the deceased from 7:PM on the date stated above, and to the best of my knowledge, from the causes stated.		and last saw her/him alive on 1-12-63	
22a. SIGNATURE W.E. Cozart MD (Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE.	
22c. DATE SIGNED 1-12-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-18-63	
23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.,	
24. FUNERAL DIRECTOR G. Wade Granberry ADDRESS 4202 Finney Ave.,		25. DATE RECD. BY LOCAL REG. JAN 14 1963	
26. REGISTRAR'S SIGNATURE Roan Smith. M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

COZART

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 P. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Avenue
St. Louis, Mo.,

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.