

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003824

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1919**

STATE/FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

Dr. O. W. Smith  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

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>Missouri</b> b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input 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 type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1365 Belt		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
			Brycie	Denise	McNeil	1 19 63						
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	Months	Days	Hours	Min.		
Fem.	Negro		1-7-63	11				11				
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				
						St. Louis, Missouri						
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE						
Lloyd McNeil			Audrey Aker									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			17. INFORMANT			Address						
						Mrs. Mary D. Jett, R.R.L., 2601 N. Whittier						
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)										Undet.		
Cerebral Hemorrhage												
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												
DUE TO (b)												
DUE TO (c)										760.0		
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.				
Atelectasis								<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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	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 1-7-63 to 1-19-63 and last saw <del>him</del> alive on 1-19-63												
Death occurred at 1:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title)					22b. ADDRESS			22c. DATE SIGNED				
Dr. O. W. Smith					2601 N. Whittier			1-23-63				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)		23e. (State)				
		1-31-63	Anatomical Board			St. Louis, Mo.						
24. FUNERAL DIRECTOR					25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
Rowland Mortuary Svc. 4104-06 Manchester					JAN 31 1963		O. W. 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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.

RECEIVED