

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-008378

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Secondary Registration District No. **1003**

Registrar's No. **2086**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 6 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Length of stay, in 1b c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
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"/> d. STREET ADDRESS (If outside, give location) 918 N. 21st. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle BROWN Last			4. DATE OF DEATH Month FEB. Day 21 Year 1963
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lakeview Ark.	9. AGE (last birthday) 42
13a. FATHER'S NAME Sam Brown		13b. MOTHER'S MAIDEN NAME Frances Rainey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Mrs. Rosie Silver 8427 Scudder	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE DUE TO (b) PULMONARY HYPERTENSION DUE TO (c) PULMONARY ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4:50 0			12. CITIZEN OF WHAT COUNTRY USA INTERVAL BETWEEN ONSET AND DEATH
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 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 2/18/63 to 2/21/63 and last saw her/him alive on 2/21/63 Death occurred at 10:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE D. E. Cozart MD (Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE	
22c. DATE SIGNED 2/21/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-28-63	23c. NAME OF CEMETERY OR CREMATORY Greenwood	
23d. LOCATION (City, town, or county) St. Louis Co. Mo.		23e. STATE (State)	
24. FUNERAL DIRECTOR Love Und. Co. 3103 Washington		25. DATE RECD. BY LOCAL REG. FEB 25 1963	
26. REGISTRAR'S SIGNATURE Neal Smith, M.D.			

D. E. Cozart, M.D.
USE BLACK INK OR TYPEWRITER RIBBON

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 *W. Claude Gordon*

Licensed Embalmer No. 3489

P. O. Address 1123 N. Taylor

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.