

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-008952

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1394**

STATE FILE NUMBER

FILED FEB 28 1963

| | | | |
|--|--|---|---|
| 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 | | Length of stay in 1b | c. CITY OR TOWN |
| St. Louis | | 22 years | St. Louis |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Inside Limits | d. STREET ADDRESS (if outside, give location) |
| Homer G. Phillips Hosp. | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 4365 St. Ferdinand Ave. |

| | | | | | | | |
|-------------------------------------|-------|--------|------|------------------|-------|-----|------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| Georgia Lampley | | | | 2 - 5 - 1963 | | | |

| | | | | | | |
|--------|------------------|--|------------------|------------------------|-----------------|----------------|
| 5. SEX | 6. COLOR OR RACE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HR |
| Female | Negro | | 6-11-22 | 40 years | Months | Days |

| | | | |
|---|-----------------------------------|--|-----------------------------|
| 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 |
| Domestic | Mrs. Ben Gold University City | Philadelphia, Miss. | U.S.A. |

| | | |
|--------------------|---------------------------|-----------------------------|
| 13a. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
| Jim Brown | Bettie Clark | James Lampley |

| | | |
|--|-------------------------|----------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
| No | 98 | James Lampley-4365 St. Ferdinand |

| | |
|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause of death) | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY | |
| IMMEDIATE CAUSE (a) | |
| Cerebral vascular accident with Hemorrhage into the Ventricles. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | |
| DUE TO (b) | |
| 331X | |
| DUE TO (c) | |

| | |
|---|--|
| 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. |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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 |
| | 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 | COUNTY | STATE |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ 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 |
| <i>[Signature]</i> | 1300 Clark Ave | 2/8/63 |

| | | | |
|---|-----------|------------------------------------|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
| Removal | 2/10/63 | Was Localn Park Cem. | Philadelphia, Mississippi |

| | | |
|------------------------------------|------------------------------|---------------------------|
| 24. FUNERAL DIRECTOR ADDRESS | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE |
| RILEY UNDERTAKERS-3759 Finney Ave. | FEB 8 1963 | <i>[Signature]</i> M.D. |

VS 300 Rev. 4/59

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DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

E-17

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 Lawrence E. Woodson

Licensed Embalmer No. 4341
P. O. Address St. Louis 13, 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.