

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009198

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2231**

STATE FILE NUMBER

**FILED MAR 8 1963**

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

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) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST Louis Mo.</b>		Length of stay in lb <b>1/2 hr.</b>	c. CITY OR TOWN <b>ST Louis Mo</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>PARK LANE Hosp</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4514 SHENANDOAH</b>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>D</b> Last <b>PETTY</b>			4. DATE OF DEATH Month <b>FEB</b> Day <b>26</b> Year <b>1963</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/05</b>
9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPERTY MGR.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	17. BIRTHPLACE (City and state or country) <b>Mo.</b>
13a. FATHER'S NAME <b>DAVID PETTY</b>		13b. MOTHER'S MAIDEN NAME <b>EMMA HOHMAN</b>	14. NAME OF HUSBAND OR WIFE Address <b>MILDRED PETTY</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>MILDRED PETTY 4514 SHENANDOAH</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Angina Pectoris</b>			INTERVAL BETWEEN ONSET AND DEATH <b>690.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b>			DUE TO (c) <b>4202</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Obesity</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	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 <b>11:30 a.m.</b> 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 <b>1-10-63</b> to <b>2-26-63</b> and last saw him alive on <b>2-20-63</b> Death occurred at <b>11:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Thos Kutis M.D.</b>		22b. ADDRESS <b>9504 Dr. Smith</b>	22c. DATE SIGNED <b>2/27/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>MAR. 1 - 63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST PAUL CHURCHYARD</b>	23d. LOCATION (City, town, or county) (State) <b>ST Louis Mo</b>
24. FUNERAL DIRECTOR <b>Thos Kutis 2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 27 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>

USE BLACK INK

OR TYPEWRITER RIBBON

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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

*Eleazar Province*

Licensed Embalmer No.

*3403*

P. O. Address

*2906 Graviss*

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.

*Dr. Province  
1504 J. Brand*

*PR 1-3334*