

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-069330

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1607**

VS 300 Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

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, Missouri		c. STATE Illinois b. COUNTY St. Clair	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If outside, give location) 1627 Gaty	
3. NAME OF DECEASED (Type or print) Baby Sanders		4. DATE OF DEATH Month 1 Day 30 Year 63	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-30-63
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) St. Louis, Missouri
13a. FATHER'S NAME Darnie Sanders		13b. MOTHER'S MAIDEN NAME Minnie Hicks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Minnie Sanders		Address 1627 Gaty	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage - atelectasis of lungs DUE TO (b) Pneumonia DUE TO (c) marked cleft palate - 760.5			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) marked hypertension			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? 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 <input type="checkbox"/> s.m. <input type="checkbox"/> 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 birth to death and last saw him alive on 1/30/63 Death occurred at 8:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Karl Smith M.D.		22b. ADDRESS 127 Mo. Trust Bldg	22c. DATE SIGNED 2/7/63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2-28-63	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Rowland Mortuary Svc		25. DATE RECD. BY LOCAL REG. FEB 14 1963	26. REGISTRAR'S SIGNATURE Karl Smith 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 _____

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.