

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009423

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1701

FILED FEB 21 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 INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4405 Greer</u>
3. NAME OF DECEASED (Type or print) First <u>Mitchell</u> Middle Last <u>Smith</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>63</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler-Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>72</u>
11. BIRTHPLACE (City and state or country) <u>Lake Hall, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Lee Smith</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>Yes W-1-</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Lee Smith</u>		Address <u>3421 Hickory St.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Probable Cerebral Arteriosclerosis</u> DUE TO (c) <u>332x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>
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 type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input 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 s.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 <u>2-9-63</u> to <u>2-14-63</u> and last saw her/him alive on <u>2-14-63</u> . Death occurred at <u>7:10 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>2601 N. Whittier</u>	22c. DATE SIGNED <u>2-14-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-18-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.,</u>
24. FUNERAL DIRECTOR <u>G. Wade Granberry</u> ADDRESS <u>4202 Finney Ave.,</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 16 1963</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

STATE OF ARIZONA
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

Decedent: _____
Sex: _____
Age: _____
Date of Birth: _____
Place of Birth: _____
Residence: _____
Occupation: _____
Cause of Death: _____
Date of Death: _____
Place of Death: _____
Date of Embalming: _____
Place of Embalming: _____
Embalmer: _____
Signature of Embalmer: _____
Date: _____

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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 _____ Signed Edward A. Flynn
Signature of Student Embalmer

Licensed Embalmer No. 4444
P. O. Address 4202 Finney Ave.

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.