

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012958

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3503** STATE FILE NUMBER

FILED APR 8 1963

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|---------------------|---------|--------------|------------|----------|-----------------------|-----------------|
| VS 300 Rev. 4/59 | AMENDED | DATE AMENDED | INSTEAD OF | DOCUMENT | MEDICAL CERTIFICATION | BY AFFIDAVIT OF |
| 2009 | | 2/11/63 | | | | |
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|---|---|---|---------------------------|--|---|---|-----------|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | |
| | | St. Louis | | | Missouri | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Homer G. Phillips | | | | 4001 Cozens | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First | Middle | Last | 4. DATE OF DEATH Month Day Year | | |
| John | | | | | Aaron | 3 | 23 | 63 |
| 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) | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HR Hours Min. |
| Male | Negro | | 10-17-1901 | | 61 | | | |
| 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 | | |
| <i>none</i> | | <i>none</i> | | <i>Miss</i> | | <i>U.S.A</i> | | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | | 14. NAME OF HUSBAND OR WIFE | | |
| <i>James Aaron</i> | | | <i>Melodie</i> | | | <i>Virginia Aaron</i> | | |
| 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 Address | | | |
| NO | | | | | <i>Virginia Aaron 4331 No market St</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) | | | | | Probable Acute Pulmonary Edema | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | Severe Anemia | | | |
| DUE TO (b) | | | | | Probable Cancer of Stomach | | | |
| 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. | | |
| 151X | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 3-21-63 to 3-23-63 and last saw ^{him} alive on 3-23-63 | | Death occurred at 9:05 P. m. 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>W. H. Whittier M.D.</i> | | | | 2601 N. Whittier | | 3-25-63 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | 23e. (State) | | |
| <i>Removal</i> | 3-29-63 | <i>Father Dixon</i> | | <i>Richwood Mo</i> | | <i>Mo</i> | | |
| 24. FUNERAL DIRECTOR ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | | |
| <i>Thomas Jackson 2741 Dixon</i> | | MAR 26 1963 | | <i>Loeal Smith M.D.</i> | | | | |

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Missouri
St. Louis
4001 Cosens

St. Louis
Homer G. Phillips

03 23 03

ASTON

John

Medic

Male

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 Probable Cancer of Stomach Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leroy W. Gunnister

Licensed Embalmer No. 4523

P. O. Address 4251 WASHINGTON

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, facts should be so stated above.

3-25-03

3-23-03

3-23-03

3-23-03

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