

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013243

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2980**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 21 1963	
1. PLACE OF DEATH a. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) 2618 PARK AVE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUSIE Middle J Last EVANS	
4. DATE OF DEATH Month MARCH Day 7 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/12/87
9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
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) Illinois	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Jeff	13b. MOTHER'S MAIDEN NAME Sadie Orr
14. NAME OF HUSBAND OR WIFE	
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 Attorney Paul Lindell Blue Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral Vascular Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) cerebral arteriosclerosis DUE TO (c) 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) congestive Heart failure PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 3-1-63 to 3-7-63 and last saw ^{her} him alive on 3-7-63 . Death occurred at 12:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE D. E. Cogart MD (Degree or title)	22b. ADDRESS 1515 Lafayette Avenue
22c. DATE SIGNED 3-8-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/14/63
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City, town, or county) (State) St. Louis Mo	
24. FUNERAL DIRECTOR Cullen-Kella ADDRESS 7267 Natural Bridge	25. DATE RECEIVED BY LOCAL REG. MAR 14 1963
26. REGISTRAR'S SIGNATURE Roan Smith, M.D.	

D. Cogart, M.D.
USE BLACK INK
OR
TYPEWRITER RIBBON

75

1275-0

3451-10-82-

(PROS)

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.

Not Embalmed

Student _____

Signature of Student Embalmer

Signed *James A. Summers*

Licensed Embalmer No. *4142*

P. O. Address *St Louis*

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.

8801 88