

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-013285

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3779** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300	DATE AMENDED	DOCUMENT
Rev. 4/59		
1		
2 <i>2/14</i>		
3		
4 <i>2</i>		
5 <i>0</i>		
6		
7 <i>1</i>		
8 <i>2</i>		
9		
10		
11		
12 <i>77-0</i>		
13		
77	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF

FILED APR 8 1963	
1. PLACE OF DEATH a. COUNTY Missouri	
2. USUAL RESIDENCE (Where deceased lived. (If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b St. Louis	
c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) 4410 Aldine Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey Middle Gee Last Gee	
4. DATE OF DEATH Month 3 Day 31 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 10-28-1925
9. AGE (last birthday) 37 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) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Coffeeville, Miss.	
11. BIRTHPLACE (City and state or country) USA	
12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Jackson	
13b. MOTHER'S MAIDEN NAME Altha Gee	
14. NAME OF HUSBAND OR WIFE Single	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi	
16. SOCIAL SECURITY NO. Dorothy Reed- 4405 Aldine St.	
17. INFORMANT Address Dorothy Reed- 4405 Aldine St.	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia INTERVAL BETWEEN ONSET AND DEATH Undet. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Nephritis DUE TO (c) 592x	
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 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 3-27-63 to 3-31-63 and last saw her him alive on 3-31-63 Death occurred at 1:45 A. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>H. Whittier</i> (Degree or title)	
22b. ADDRESS 2601 N. Whittier	
22c. DATE SIGNED 4-1-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 4-6-63	
23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cem.	
23d. LOCATION (City, town, or county) (State) Kirkwood, Missouri	
24. FUNERAL DIRECTOR ADDRESS A. L. Beal Und. Co. 4303 Delmar	
25. DATE RECD. BY LOCAL REG. APR 3 1963	
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

Missouri
St. Louis
4410 Atkins

St. Louis
Homer G. Phillips

31 03

03

HEALTH

Medico

State

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 Arthur L. Heilbard

Licensed Embalmer No. 4291

P. O. Address 3100 Easton 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.

30-1-1