

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

3373-63-013643
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED MAR 28 1963

VS 300 Rev. 4/59	DATE AMENDED	
1		
2 400X 30		
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4 1		
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12 68-0		
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68		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

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		Length of stay in 1b	c. CITY OR TOWN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits	d. STREET ADDRESS
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
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"/>
10a. USUAL OCCUPATION (Give kind of work done in last working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	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)		17. INFORMANT	Address
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)		b. years	
DUE TO (b)		332X	
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.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <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		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	
21. I attended the deceased from _____ 1961 to present and last saw her alive on 3/20/63		Death occurred at _____ 7:35 AM 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
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county)		23e. DATE RECD. BY LOCAL REG.	
24. FUNERAL DIRECTOR		26. REGISTRAR'S SIGNATURE	

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Removal of body 3-23-1963
2504 Woodson Rd Overland, Mo.
M^r. Lebaron Cemetery
St. Ann, Mo.
MAR 22 1963
Coal Smith, M.D.

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

David C. Gibson

Licensed Embalmer No. 34574

P. O. Address

St. Louis, Mo.

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.