MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-63-014286

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 674

FILED MAR 18 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY St Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Louis County Hosp Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY
c. CITY OR TOWN Lincoln Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) R.R. # 1 Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Lucille Middle: Last: Malone
4. DATE OF DEATH Month: 2 Day: 26 Year: 63
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH ?
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) Housework
10b. KIND OF BUSINESS OR INDUSTRY At home
11. BIRTHPLACE (City and state or country) ?
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Ed Eldridge
13b. MOTHER'S MAIDEN NAME Carrie Kern
14. NAME OF HUSBAND OR WIFE James Malone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of
16. SOCIAL SECURITY NO.
17. INFORMANT Carrie Eldridge Address Lincoln, Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertension and heart condition
INTERVAL BETWEEN ONSET AND DEATH Years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (Under treatment of physician in Lincoln, Ill.)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at 1:05 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Raymond Kaiser (Degree or title) Coroner
22b. ADDRESS Clayton, Missouri
22c. DATE SIGNED 3/2/63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 2-27-63
23c. NAME OF CEMETERY, OR CREMATORY Local Cemetery
23d. LOCATION (City, town, or county) Lincoln (State) Ill

24. FUNERAL DIRECTOR Holland & Barry ADDRESS Lincoln, Ill
25. DATE RECD. BY LOCAL REG. 2-27-63
26. REGISTRAR'S SIGNATURE John E. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Frank Prokopf

Licensed Embalmer No. 4356

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.