

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

63-017426

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3898

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 17 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
2059		St. Louis		25 years		St. Louis		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
Homer G. Phillips				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		5220 Page				
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
Mary			Mary		Brooks	4 3 63		4	3	63
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	Months	Days	Hours	Min.
Fem.	Negro		8-25-1907	55						
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			
UNKNOWN					Mississippi		USA			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE					
Samuel Ladson			Anne Ladson		John Brooks					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO					Bill Leggins		4232W page			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)										Undet.
Congestive Heart Failure										
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										
DUE TO (b)										
Constrictive Pericarditis										
DUE TO (c)										434.3
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.	3-21-63								
	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		
				4-3-63		4-3-63		4-3-63		
21. I attended the deceased from _____ to _____ and last saw him alive on _____										
Death occurred at _____ 7:35 A. _____ 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		
[Signature]						2601 N. Whittier		4-3-63		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)			(State)		
		4 8 63	Father Dickson		Kirkwood mo					
24. FUNERAL DIRECTOR ADDRESS					25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE				
A. H. Burke 3901 Ashland					APR 5 1963	Earl Smith, M.D.				

Missouri

St. Louis

2222 Page

St. Louis

Home G. Phillips

Missy

Negro

3 3 3

Brooks

See

Unfit

Constrictive Heart Failure

Constrictive Pericarditis

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,

of by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed *Lynn W. Cook*

X X

Ed-S-A

XX

Ed-S-A

Ed-S-E

.A

Ed-S

Licensed Embalmer No. 4628

P. O. Address 1238 W. Kingshighway

Ed-S-A

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.