

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017603

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3849**

FILED APR 17 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Length of stay in 1b years	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4207 W. San Francisco Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle WALKER Last FARRIS			4. DATE OF DEATH Month April Day 2, Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Physician, Surgeon		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	9. AGE (last birthday) 84 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Granville, Tennessee		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Farris		13b. MOTHER'S MAIDEN NAME Julia	
14. NAME OF HUSBAND OR WIFE Cecelia Farris		17. INFORMANT Address Mrs. Cecelia Farris, 4207 W. San Francisco	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephrosclerosis with terminal uremia DUE TO (b) Generalized arteriosclerosis DUE TO (c) 446x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 mths. unk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease			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 Nov 14 - 1958 to April 3 1963 and last saw him ^{look} alive on April 2 1963 Death occurred at 12:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Henry Cooper M.D.		22b. ADDRESS 818 Olive St. St. Louis	22c. DATE SIGNED 4/4/63
23a. REMOVAL BY via Motor		23b. DATE 4-6-1963	23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery
24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Bl.		23d. LOCATION (City, town, or county) (State) Sesser, Franklin Co., Illinois	25. DATE RECD. BY LOCAL REG. APR 4 1963
26. REGISTRAR'S SIGNATURE Loal Smith, M.D.			

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Dr. Robert G. Warner
Paul Brown Bldg.
CH 1-4747

HOURS: Tues. till 3:30 PM
No Wednesday Hours
Thurs: 12 noon till 3:30 PM

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 Robert E. Mublerman

Licensed Embalmer No. 4916

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.