

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-018289

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4853**

FILED MAY 9 1963

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	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2718^c Stoddard		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2718^a Stoddard St
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First GEORGE Middle SUTTON Last			4. DATE OF DEATH Month 5 Day 1 Year 63		
5. SEX MALE	6. COLOR OR RACE colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-21-87	9. AGE (last birthday) 75 yrs	IF UNDER 1 YEAR Months 4 Days 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FOUNDRY		11. BIRTHPLACE (City and state or country) MISS U.S.A	

13a. FATHER'S NAME GEORGE SUTTON		13b. MOTHER'S MAIDEN NAME MATILDA BEASLEY		14. NAME OF HUSBAND OR WIFE ANNA Belle SUTTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ANNA Belle SUTTON 2718^a Stoddard	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic deep O-Carditis DUE TO (b) Chronic nephritis, Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 592x		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.) 592x	
---	---	---	--

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 ST. LOUIS	COUNTY ST. LOUIS	STATE MO
--	--	---	--	----------------------------	--------------------

21. I attended the deceased from **4-23-63** and last saw him alive on **4-30-63**
Death occurred at **2:30 p** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Smith M.D.	22b. ADDRESS 3000^a Kastan	22c. DATE SIGNED 5/4/63 (State)
--	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 5-6-63	23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM	23d. LOCATION (City, town, or county) ST. LOUIS CITY MO
---	----------------------------	--	---

24. FUNERAL DIRECTOR A. F. WALTON 2707 Stoddard	25. DATE RECD. BY LOCAL REG. MAY 4 1963	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
---	---	--

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
 1
 2 **22**
 3
 4 **2**
 5 **1**
 6
 7 **1**
 8 **2**
 9
 10
 11
 12 **90-0**
 13
 90
 USE BLACK INK OR TYPEWRITER RIBBON
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DATE AMENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Taylor

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.