

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021479

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5593**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 3 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

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)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b <b>3 Mos.</b>		c. CITY OR TOWN <b>Rock Hill</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bernard Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1341 McKinley Ave.</b>
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		5. AGE (last birthday)
First <b>MAX</b> Middle <b>P.</b> Last <b>DELLING</b>			Month <b>May</b> Day <b>24</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-1869</b>	9. AGE (last birthday) <b>93</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Stonecutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Masonry</b>	11. BIRTHPLACE (City and state or country) <b>Burstadt, Germany</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>William Christian Delling</b>		13b. MOTHER'S MAIDEN NAME <b>Bertha Augusta Hauptmann</b>		14. NAME OF HUSBAND OR WIFE <b>Martha Marie Delling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO. <b>64</b>		17. INFORMANT <b>Arthur F Delling, 928 Dwyer Ave., Glendale 22, Mo.</b>	
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) <b>Cerebro-vascular accident</b>					<b>4 days</b>
DUE TO (b) <b>Cerebral arteriosclerosis</b>					<b>Over 2 years</b>
DUE TO (c) <b>331X</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized arteriosclerosis</b>					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 Month, Day, Year a.m. 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
21. I attended the deceased from <b>Sept 1, 1962</b> to <b>May 24, 1963</b> and last saw him alive on <b>May 22, 1963</b> Death occurred at <b>2:50 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>James B. Jones</i> MD		22b. ADDRESS <b>9313 Manchester Ave. St. Louis 19, Mo.</b>		22c. DATE SIGNED <b>5-27-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-28-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Churchyard</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>	
24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 27 1963</b>		26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>	

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James B Jones MD

WO 1-5656

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 Malvin Barlow

Licensed Embalmer No. 4903

P. O. Address St. Louis

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.