

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021576

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5100**

FILED MAY 17 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 1 day 6 hours		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		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 St. Louis-Little Rock Hospital, Inc.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4124 Page Blvd.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Fletcher			First Middle Last - - Freeman			4. DATE OF DEATH Month Day Year May 8, 1963						
5. SEX Male		6. COLOR OR RACE Col.		7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH April 5, 1888		9. AGE (last birthday) 75 yrs		IF UNDER 1 YEAR Months Days Hours Min. 1 3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Train Porter				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Fort Valley Ga		12. CITIZEN OF WHAT COUNTRY U S A				
13a. FATHER'S NAME Fletcher Freeman Sr				13b. MOTHER'S MAIDEN NAME Agnes ?				14. NAME OF HUSBAND OR WIFE Josephine				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)				16. SOCIAL SECURITY NO. 266		17. INFORMANT Address Josephine Freeman 4124 Page Blvd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Ca of Lung, Rt.										INTERVAL BETWEEN ONSET AND DEATH 1 yr		
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) 163x								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 May 7, 1963 to May 8, 1963 and last saw her/him alive on May 8, 1963 Death occurred at 7 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title) Mrs. O. M. D.						22b. ADDRESS 1755 South Grand Blvd.			22c. DATE SIGNED 5/9/63 (State)			
23b. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-13-1963		23c. NAME OF CEMETERY OR CREMATORY Calvary				23d. LOCATION (City, town, or county) St. Louis		Mo		
24. FUNERAL DIRECTOR James H. Randle & Son Funeral Home						25. DATE RECD. BY LOCAL REG. MAY 11 1963		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.				

USE BLACK INK OR TYPEWRITER RIBBON

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 Esther K. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Washington

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.