

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022105

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5954** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

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<p><b>FILED JUN 13 1963</b></p> <p>1. PLACE OF DEATH a. COUNTY <b>St. Louis, Mo.</b></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b> Length of stay in 1b</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. # 1</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>MO</b> b. COUNTY</p> <p>c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <b>5155 ENLIGHT</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <b>BETTY Baby Girl ANN Rall</b></p>		<p>4. DATE OF DEATH Month Day Year <b>5-25-1963</b></p>	
<p>5. SEX <b>FEMALE</b></p>	<p>6. COLOR OR RACE <b>NEGRO</b></p>	<p>7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b></p>	<p>11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO</b></p>
<p>12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b></p>		<p>13. FATHER'S NAME <b>CHARLES MONROE RALL</b></p>	
<p>13a. FATHER'S NAME</p>		<p>13b. MOTHER'S MAIDEN NAME <b>ROSTIE MAE BRANCH</b></p>	
<p>14. NAME OF HUSBAND OR WIFE</p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NO</b></p>	
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Address <b>ST. LOUIS CITY HOSP. # 1.</b></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <b>IMMATURITY</b></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>776x</b></p> <p>DUE TO (c)</p>			<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>			<p>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</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <b>5-25-63</b> to <b>5-25-63</b> and last saw her/him alive on <b>5-25-63</b>. Death occurred at <b>7:05 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE (Degree or title) <b>Shelton H.D.</b></p>		<p>22b. ADDRESS <b>1515 Lafayette Ave.</b></p>	<p>22c. DATE SIGNED <b>5-25-63</b></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-29-63</b></p>	<p>23b. DATE</p>	<p>23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b></p>	<p>23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b></p>
<p>24. FUNERAL DIRECTOR ADDRESS <b>Rowland Mortuary Svc. 4104-06 Manchester</b></p>		<p>25. DATE RECD. BY LOCAL REG. <b>JUN 6 1963</b></p>	<p>26. REGISTRAR'S SIGNATURE <b>Roan Smith. M.D.</b></p>

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.