

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022774
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1640

FILED JUN 5 1963

VS 300
Rev. 4/59

1 4000

2 204

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u>		Length of stay in 1b <u>93 days</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1221 San Jacinto</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>B.</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>'63</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-24-05</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	9. AGE (last birthday) <u>58</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>25</u> IF UNDER 24 HR: Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>St. Louis MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Louis Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Charlotte, Fletcher</u>	
14. NAME OF HUSBAND OR WIFE <u>Elva Cory</u>		17. INFORMANT <u>Charlotte Smith</u> Address <u>6334 Southwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates)			
16. SOCIAL SECURITY NO. <u>584</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombophlebitis of right leg</u>			?
DUE TO (c) <u>763X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 <u></u> a.m. <u></u> 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 <u>Feb 15, '63</u> to <u>May 19, '63</u> and last saw her/him alive on <u>May 19, '63</u> Death occurred at <u>10:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul Beckwith</u> (Degree or title)		22b. ADDRESS <u>Koch, MO.</u>	22c. DATE SIGNED <u>5-19-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 22, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Cty., Mo.</u>
24. FUNERAL DIRECTOR <u>A. H. Bocklage 6536 Clayton Rd.</u>		25. DATE RECD. BY LOCAL REG. <u>5-21-63</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy</u>

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

John J. Harris

Licensed Embalmer No. 4108

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.