

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025719

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6471** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300 Rev. 4/59

1  
2 **225**  
3  
4 **3**  
5 **0**  
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7 **9**  
8 **1**  
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12 **75-0**  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
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"/>		d. STREET ADDRESS <b>1605 FRANKLIN</b>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>BURNETT</b> Last <b>JR.</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>1963</b>			5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <b>4/26/22</b>		9. AGE (last birthday) <b>41</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired). <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (City and state or country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY <b>???</b>		13a. FATHER'S NAME <b>JOHN BURNETT SR.</b>			13b. MOTHER'S MAIDEN NAME <b>SARAH SMITH</b>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) <b>NO</b> (If yes, give war or type of service)		17. INFORMANT <b>ST. LOUIS CITY HOSP. #1.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT AND LEFT LOWER LOBES</b> DUE TO (b) <b>AMOEBA POLYMORPHA (MICRO ORGANISM)</b> DUE TO (c) <b>490x</b> Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>ALCOHOLISM, CHRONIC, WITH DELIRIUM TREMENS</b>		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	
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 <b>5/19/63</b> to <b>5/25/63</b> and last saw her/him alive on <b>5/25/63</b> Death occurred at <b>3:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Ralph A. Kinsella, Jr.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>6/3/63</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6-29-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>				(State)	
24. FUNERAL DIRECTOR <b>Ogden 4106 Manchester</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>JUN 20 1963</b>		26. REGISTRAR'S SIGNATURE <b>Lois Smith, M.D.</b>					

Ralph A. Kinsella, Jr.  
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 \_\_\_\_\_

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.