

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025751

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6337**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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Thomas J. Kidzon, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No. **318**
FILED JUN 21 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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 CITY HOSP. # 1				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1505 A Webster				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MATTIE CLIFTON						4. DATE OF DEATH Month 6 Day 13 Year 63		5. SEX Female		6. COLOR OR RACE Negro	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/25/1886		9. AGE (last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) Miss.		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME Susie Kelly				14. NAME OF HUSBAND OR WIFE Ben Clifton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Arlean Foster 1505 A Webster					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus massive										INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) from Unknown Site.											
DUE TO (c) 465x											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease								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 checked="" type="checkbox"/> NO <input 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 6/10/63 to 6/13/63 and last saw her/him alive on 6/13/63 Death occurred at 7:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Thomas J. Kidzon</i> (Degree or title)						22b. ADDRESS 1515 LAFAYETTE AVE.			22c. DATE SIGNED 6/13/63 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 20, 1963		23c. NAME OF CEMETERY OR CREMATORY National Cemetery			23d. LOCATION (City, town, or county) Jefferson Barracks Mo.				
24. FUNERAL DIRECTOR <i>E. B. Kellie</i> ADDRESS 1221 N. Grand Blvd.				25. DATE RECD. BY LOCAL REG. JUN 15 1963		26. REGISTRAR'S SIGNATURE <i>Roald Smith, M.D.</i>					

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

Oliver E. Crumley

Licensed Embalmer No. 5185

P. O. Address 1221 W Grand Ave

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.