

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026455

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No. 1003

6473

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_

FILED JUN 28 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		Length of stay in 1b	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 (If outside, give location) <b>2825 LA SALLE</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>PEARLINE THOMAS</b>			4. DATE OF DEATH Month Day Year <b>MAY 27, 1963</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/05</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (last birthday) <b>57</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
13a. FATHER'S NAME <b>TOM JONE</b>		13b. MOTHER'S MAIDEN NAME <b>MILLIE DOUGLAS</b>	11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
17. INFORMANT <b>ST. LOUIS CITY HOSP. #1</b>		Address	
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>Institution &amp; Sepsis</b> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Squamous Carcinoma of anus - post operative</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 weeks</b> <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>191.5</b>			PART III. If deceased was female 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.	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>2/11/63</b> to <b>5/27/63</b> and last saw her/him alive on <b>5/27/63</b> Death occurred at <b>lp</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Queen Holm M.D.</i>		22b. ADDRESS <b>1515 LAFAYETTE AVE</b>	22c. DATE SIGNED <b>5/27/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-29-63</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Oden, 4106 Manchester</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 20 1963</b>	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>

VS 300 Rev. 4/59  
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

STATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

HOLM

**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.

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