

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029802

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

8071

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 15 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY															
		St. Louis		24yrs		Missouri																	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits		d. STREET ADDRESS (If outside, give location)		Reside on Farm		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>															
Homer G. Phillips Hospital		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		3968A Cook Ave		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			Month			Day			Year		
IRENE			COLEMAN									Aug			6			1963					
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR											
Female		Col				6-19-1913		50		Months		Days		Hours		Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY,																	
Housework				Little Rock Ark		U S A																	
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
Thomas Bradley				Millie Johnson																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address											
No								Rosie Lee Walker				4911 Highland Ave											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH													
IMMEDIATE CAUSE (a)										4 days													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										331X													
DUE TO (b)																							
DUE TO (c)																							
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 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		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 _____ to _____ and last saw her alive on _____		Death occurred at _____ on the _____ date stated above, and to the best of my knowledge, from the causes stated.																					
22a. SIGNATURE (Degree of title)		22b. ADDRESS		22c. DATE SIGNED (Date)																			
[Signature]		[Address]		8-7-63																			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		STATE															
Removal		Aug 12-63		Washington Park		St. Louis Co.		MO															
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.				26. REGISTRAR'S SIGNATURE															
JAS H. RANDLE & SON 3133 Bell Ave				AUG 8 1963				Loan Smith, M.D.															

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

SC01



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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,

0-17

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Jefferson M. Henderson

Licensed Embalmer No. 5072

P. O. Address 4535 Washington

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.