

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029862

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7203

STATE FILE NUMBER

FILED JUL 19 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

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 St. Louis, Missouri		Length of stay in 1b Over 13 yrs.		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 State Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 2525a Newhouse				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET DILDINE						4. DATE OF DEATH Month Day Year July 9, 1963					
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-26-04		9. AGE (last birthday) 58		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Formerly: Inspector				10b. KIND OF BUSINESS OR INDUSTRY Carter Carburetor		11. BIRTHPLACE (City and state or country) Seymour, Mo.		12. CITIZEN OF WHAT COUNTRY American			
13a. FATHER'S NAME Jesse Marlin				13b. MOTHER'S MAIDEN NAME Judy Stafford				14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. Nil		17. INFORMANT Address St. Louis State Hospital Medical Records					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Septicemia											
DUE TO (b) Decubital ulcer 0534											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
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 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 11-4-49 to 7-9-63 and last saw her ^{him} alive on 7-9-63				Death occurred at 6:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Robert H. W...</i>						22b. ADDRESS 5400 Arsenal		22c. DATE SIGNED 7-10-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7/12/63		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.					
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.,				ADDRESS		25. DATE RECD. BY LOCAL REG. JUL 11 1963		26. REGISTRAR'S SIGNATURE <i>Loal 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 Isy W Wilkinson

Licensed Embalmer No. 3575

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.

Robert H. ...