

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029904

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7088 STATE FILE NUMBER

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <u>2059</u>				
3				
4 <u>0</u>				
5 <u>1</u>				
6				
7 <u>1</u>				
8 <u>1</u>				
9	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
10				
11				
12 <u>91-3</u>				
13				
<u>91</u>				

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
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.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		17. INFORMANT Address	
IMMEDIATE CAUSE (a)		PART III. If deceased was female was there a pregnancy in last 90 days.	
DUE TO (b)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year s.m. -p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____		20f. CITY, TOWN, OR LOCATION	
22a. SIGNATURE (Degree or title)		20g. COUNTY	
22b. ADDRESS		20h. STATE	
22c. DATE SIGNED		21. Death occurred at _____ A. M. on the _____ date stated above, and to the best of my knowledge, from the causes stated.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORY	
23b. DATE		23d. LOCATION (City, town, or county)	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.	
ADDRESS		26. REGISTRAR'S SIGNATURE	

Albert H. Hoppe Inc., 4700 Washington, Blvd. **JUL 8 1963** *Loan Smith, M.D.*

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

Robert M. Murray

Licensed Embalmer No.

3749

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.

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