

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030317

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7369

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 25 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	SHOULD READ	BY AFFIDAVIT OF
1						
2 105						
3						
4 3						
5 2						
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7 1						
8 2						
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10						
11						
12 770						
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77						

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>5218 Page</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle Last <b>Moses</b>		4. DATE OF DEATH Month <b>7</b> Day <b>13</b> Year <b>63</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-3-07</b>
9. AGE (last birthday) <b>56</b>		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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>	11. BIRTHPLACE (City and state or country) <b>Louisiana</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>Andrew Caldwell</b>	
13b. MOTHER'S MAIDEN NAME <b>May Lizzo</b>		14. NAME OF HUSBAND OR WIFE	
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 <b>Ella Lawrence, 5218 Page</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>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular Disease</b>			
DUE TO (c) <b>443x</b>			
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. 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 <b>7-7-63</b> to <b>7-13-63</b> and last saw her alive on <b>7-13-63</b> Death occurred at <b>5120 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. H. Utley, M.D.</i>		22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>7-15-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>	23b. DATE <b>July 19, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis MO.</b>
24. FUNERAL DIRECTOR <b>F. A. Sheen 4214 Delmar</b>		DATE RECD. BY LOCAL REG. <b>JUL 17 1963</b>	REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Oakman

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.