

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 29 1963
Primary Registration District No. **1003**
Registrar's No. **8365**
STATE FILE NUMBER **63-033560**

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY D. O. A. Homer Phillips		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis,	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips D.O.A.		d. STREET ADDRESS (If outside, give location) 3707 Cass	
3. NAME OF DECEASED (Type or print) Earl Daniels		4. DATE OF DEATH Aug. 15, 1963	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/10/96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (City and state or country) Mississippi	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Green Daniels		13b. MOTHER'S MAIDEN NAME Gena Meadows	14. NAME OF HUSBAND OR WIFE Lillie Daniels
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service. Yes 9/7/18 to 7/17/19.		17. INFORMANT Address Lillie Daniels #3707 Cass	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Hypertension DUE TO (c) 443X			
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ s.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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L. Taylor, Coroner		22b. ADDRESS 1300 Clark Ave.	22c. DATE SIGNED 8-16-63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
8/19/63	8/19/63	National Cemetery	Jefferson Barr. Mo.
24. FUNERAL DIRECTOR ADDRESS Williams Fun. Hm. 5511 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. AUG 16 1963	26. REGISTRAR'S SIGNATURE Earl 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 Leroy W. Penninger

Licensed Embalmer No. 4523

P. O. Address 4257 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.