

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

8525 **63-033606**  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 6 1963

VS 300  
Rev. 4/59

1

2 **210**

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4 **2**

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) <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>Hornor Philip Hosp</b>		d. STREET ADDRESS (If outside, give location), <b>3861 ST LOUIS</b>	
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>L</b> Middle <b>W</b> Last <b>ELEBY</b>			4. DATE OF DEATH Month <b>Aug</b> Day <b>20</b> Year <b>1963</b>
5. SEX <b>MALE</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>2/2/1891</b>
9. AGE (last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done in most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state of country) <b>Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>US</b>		13a. FATHER'S NAME <b>Bob Eleby</b>	
13b. MOTHER'S MAIDEN NAME <b>Jennie Jackson</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if in known) (If yes, give war or dates of war) <b>No</b>		SOCIAL SECURITY NO. _____	
16. INFORMANT <b>William Eleby</b>		Address <b>1409 Mt Clair</b>	
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>Atherosclerotic Heart Disease</b> DUE TO (b) <b>Generalized Atherosclerosis</b> DUE TO (c) <b>4200</b>			INTERVAL BETWEEN ONSET AND DEATH _____
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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>MS P</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Nelaw L. Taylor, Coroner</b>		22b. ADDRESS <b>1300 Clark Ave.</b>	
22c. DATE SIGNED <b>8-22-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>26 Aug 63</b>		23b. DATE <b>26 Aug 63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis Co Mo</b>	
24. FUNERAL DIRECTOR <b>Reliable Funeral Sys</b>		ADDRESS <b>1389 N Union</b>	
25. DATE RECD. BY LOCAL REG. <b>AUG 22 1963</b>		26. REGISTRAR'S SIGNATURE <b>Wood 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 James A. Hyatt

Licensed Embalmer No. 4441

P. O. Address 1389 Union

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.