

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034641

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2587

FILED SEP 9 1963

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT
Rev. 4/59	
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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) OR TOWN <b>Koch</b>		c. CITY OR TOWN <b>St. Louis</b> <b>5076 Cabanne</b>	
Length of stay in 1b <b>186 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5076 Cabanne</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carl Louis Singleton</b>		4. DATE OF DEATH Month Day Year <b>August 14, 1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-17-21</b>
9. AGE (last birthday) <b>41</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Hazel Singleton</b>	
13b. MOTHER'S MAIDEN NAME <b>Edna Jackson</b>		14. NAME OF HUSBAND OR WIFE <b>—</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records of Robt. Koch Hosp. - Koch, Mo.</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>Fibro-carcinoma pulmonary Tuberculosis with cavity.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Acute pulmonary edema</b> DUE TO (b) <b>—</b> DUE TO (c) <b>—</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) <b>002.1</b>			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 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>2-9-63</b> to <b>8-14-63</b> and last saw <del>him</del> <sup>her</sup> alive on <b>8-14-63</b> Death occurred at <b>5:25 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <b>Rea Beck N. D.</b>		22b. ADDRESS <b>Robt. Koch Hosp. - Koch, Mo.</b>	
22c. DATE SIGNED <b>8-14-63</b>		23. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-19-63</b>	
23c. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>		24. FUNERAL DIRECTOR <b>G. Wade Granberry 4202 Finney Ave.,</b>	
25. DATE RECD. BY LOCAL REG. <b>8-15-63</b>		26. REGISTRAR'S SIGNATURE <b>June M. [Signature]</b>	

**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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.,

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.