

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037502

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9358** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

FILED SEP 26 1963

VS 300 Rev. 4/59	DATE AMENDED	
1		
2		215
3		
4		0
5		1
6		
7		0
8		1
9		
10		
11		
12		75-0
13		

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
		ST. LOUIS, MO				Mo.				St. Louis		Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
ST. LOUIS CITY HOSP. #1.						4820 Pennsylvania											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH											
First			Middle			Last			Month			Day			Year		
CLIFFORD			DUGGIN						SEPT.			17,			1963		
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		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR					
Male		White				6/20/30		33		Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY					
Locomotive Engineer				Terminal R.R.				Missouri				U.S.A.					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE									
James Duggin				Nellie Burch				Gladys Duggin									
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				Address					
No								Gladys Duggin				4820 Pennsylvania					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a)																	
DUE TO (b)																	
DUE TO (c)																	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT		SUICIDE		HOMICIDE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)									
20c. TIME OF INJURY		Hour		Month, Day, Year													
		a.m.		p.m.													
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 <u>9/15/63</u> to <u>9/17/63</u> and last saw her/him alive on <u>9/17/63</u> Death occurred at <u>12 n.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title)						22b. ADDRESS						22c. DATE SIGNED					
<u>Richard L. Phillips M.D.</u>						<u>1515 LAFAYETTE AVE</u>						<u>9/17/63</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)									
Burial		9/20/1963		New St. Marcus Cem.				St. Louis Mo.									
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE											
<u>Thomas Katis 2906 Graves</u>				SEP 18 1963		<u>Loat Smith. M.D.</u>											

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

Corley Thompson Jr

Licensed Embalmer No.

4861

P. O. Address

St Louis 9 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.