

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037806
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **9641**

FILED OCT 4 1963	
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. Length of stay in 1b _____ c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY _____ c. CITY OR TOWN ST. LOUIS, MO. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 3147 A BRANLINER Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First QUINCY Middle _____ Last McFadden	
4. DATE OF DEATH Month 9 Day 18 Year 63	
5. SEX MALE	6. COLOR OR RACE NEGRO
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/15/63
9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days 2 Hours 7 Min 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (City and state or country) ST. LOUIS, MO	12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME SPENCE MCFADDEN	13b. MOTHER'S MAIDEN NAME MINNIE LEE WILSON
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) NO
16. SOCIAL SECURITY NO. _____	17. INFORMANT ST. LOUIS CITY HOSP. #1. Address _____
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 776x	
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	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 9-15-63 to 9-18-63 and last saw her/him alive on 9-18-63 Death occurred at 6:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE McFadden M.D. (Degree or title)	22b. ADDRESS 1515 Lafayette Avenue
22c. DATE SIGNED 9-18-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) _____	23b. DATE 9-30-63
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR _____ ADDRESS _____	25. DATE RECD. BY LOCAL REG. SEP 27 1963
26. REGISTRAR'S SIGNATURE Loed Smith, M.D.	

KEATON
 USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT
 DATE AMENDED
 1
 2 **22/19**
 3
 4 **2**
 5 **0**
 6
 7 **0**
 8 **1**
 9
 10
 11
 12 **75-6**
 13
 75

BY AFFIDAVIT OF

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.