

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038369

STATE FILE NUMBER

Registration District No. 347 Primary Registration District No. 541 Registrar's No. 2955

FILED OCT 10 1963

DO NOT WRITE ON THIS STUB AMENDED

VS 300 Rev. 4/59
1 4002
2 4028
3
4 3
5 2
6
7 1
8 491x
9
10
11 45-0
13

DATE AMENDED
INSTEAD OF
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis County | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Co. Hosp. Clayton Length of stay in 1b 3 mos | | c. CITY OR TOWN St. Louis Inside Limits Kinloch Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hosp. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 920 Warne Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Goldie Middle McGILL Last McGILL | | | 4. DATE OF DEATH Month 9 Day 19 Year 63 |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Unknown |
| 9. AGE (last birthday) Unknown | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 11. BIRTHPLACE (City and state or country) Pawl, Mississippi |
| 12. CITIZEN OF WHAT COUNTRY U.S. A. | | 13. FATHER'S NAME James Coffee | |
| 14. NAME OF HUSBAND OR WIFE Henderson McGill | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | |
| 16. SOCIAL SECURITY NO. <input type="checkbox"/> | | 17. INFORMANT Oscar McClain Address <input type="checkbox"/> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) Generalized Arteriosclerosis, Sickle Cell Trait, Emphysema | | | 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 <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. _____ | 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 2-6-63 to 9-19-63 and last saw her/him alive on 9-19-63 Death occurred at 6:45 P.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE John M. Jarman, M.D. (Degree or title) | | 22b. ADDRESS 601 So. Brentwood, Clayton Mo. | 22c. DATE SIGNED 9/21/63 |
| 23a. BURIAL, CREMATION, OR DISPOSAL (Specify) BURIAL | 23b. DATE Sept. 24, 1963 | 23c. NAME OF CEMETERY OR CREMATORY Oak Dale | 23d. LOCATION (City, town, or county) (State) Lemay (St. Louis) Co. Mo. |
| 24. FUNERAL DIRECTOR McClain Funl. Home ADDRESS 1841 Cass | 25. DATE RECD. BY LOCAL REG. 9/24/63 | 26. REGISTRAR'S SIGNATURE John B. Murphy, M.D. | |

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, Wallace R. Killian

Licensed Embalmer No. 4926

P. O. Address 5135 Rotus

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.