

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041342

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10105**

FILED OCT 17 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
Length of stay in 1b over 25 yrs.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If outside, give location) 1942a Montgomery	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES DALEY			4. DATE OF DEATH Month Day Year Oct. 9, 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-20-04
9. AGE (last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John		13b. MOTHER'S MAIDEN NAME Unknown	
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 serv.) no		16. SOCIAL SECURITY NO. [Redacted]	
17. INFORMANT Hospital Records		Address 2712 E 57 ST. Long Beach Cal	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Subarachnoidal, hemorrhage of right occipital lobe		330X	
DUE TO (c) General Atherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease.			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 May 11, 1938 , to Oct. 9, 1963 and last saw him alive on Oct. 9, 1963 Death occurred at 10:35 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS 5400 Arsenal St.	22c. DATE SIGNED 10-11-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-12-63	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) St. Louis Mo
24. FUNERAL DIRECTOR O'SULLIVAN-MUCKLE-KRON MORTUARY		25. DATE RECD. BY LOCAL REG. OCT 11 1963	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
8806 JENNINGS ROAD			

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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2 **226**
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4 **0**
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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

Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address

St Louis 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.