

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-041396

DO NOT WRITE ON THIS STUB AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10733** STATE FILE NUMBER

FILED NOV 7 1963

VS 300 Rev. 4/59	DATE AMENDED	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

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) St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5610 Clemens		d. STREET ADDRESS (If outside, give location) 5610 Clemens	
3. NAME OF DECEASED (Type or print) First Middle Last Flla Dupree		4. DATE OF DEATH Month Day Year 10-26-63	
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 3-10-1888-76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (City and state or country) Tenn.	
13a. FATHER'S NAME Unk.		14. NAME OF HUSBAND OR WIFE John Dupree	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT John Dupree 5610 Clemens	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) 4222 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Jan 1963 to Oct 1963 and last saw her alive on 10/24/63 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 (Degree or title) Clyde B. Kane M.D.		22b. ADDRESS 706 Walton	
22c. DATE SIGNED 10/28/63		23c. NAME OF CEMETERY OR CREMATORY Greenwood	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rampola		23d. LOCATION (City, town, or county) St. Louis, Mo.	
24. FUNERAL DIRECTOR J. McClendon 4535 Washington		25. DATE RECD. BY LOCAL REG. OCT 29 1963	
		26. REGISTRAR'S SIGNATURE Loed Smith, M.D.	

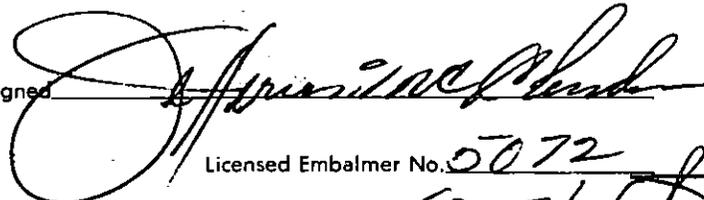
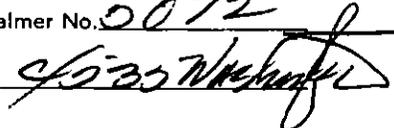
USE BLACK INK OR TYPEWRITER RIBBON

77-888 - 12

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. 5072
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.

ONE