

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-041460

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10408**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

FILED OCT 31 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. 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		c. CITY OR TOWN UNIVERSITY CITY	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MISSOURI BAPTIST HOOSP.		d. STREET ADDRESS (If outside, give location) 6930 KINGSBURY	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle C. Last FRENCH			4. DATE OF DEATH Month OCT Day 18 Year 1963
5. SEX M.	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRES. FRENCH-GERLEMAN		10b. KIND OF BUSINESS OR INDUSTRY ST. JOSEPH MO	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME FRENCH ALBERT FRENCH		13b. MOTHER'S MAIDEN NAME ANNABELLE HOUSTON	14. NAME OF HUSBAND OR WIFE LOUISE FRENCH
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. 331X	
17. INFORMANT MRS. LOUIS FRENCH 6930 KINGSBURY		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertension DUE TO (c) arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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.) 10:45 PM		20f. CITY, TOWN, OR LOCATION ST. LOUIS COUNTY STATE	
21. I attended the deceased from 10-17-63-10:45 PM to 10-18-63 and last saw ^{her} him alive on 10-18-63 Death occurred at 3: PM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Describe or title) Pol Lawrence H. Keller M.D.		22b. ADDRESS 3121 Grand	22c. DATE SIGNED 10-19-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral	23b. DATE 10-21-63	23c. NAME OF CEMETERY OR CREMATORY OHM GROVE Cem.	23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO.
24. FUNERAL DIRECTOR ADDRESS LUPTON CHAPEL 733 DELMAR		25. DATE RECD. BY LOCAL REG. OCT 19 1963	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

(FERENCE)
DR. C. H. KILKER
3121 N. GRAND - JE156900
SAT - 10 to 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 Clarence S. Murray

Licensed Embalmer No. 4011

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.