

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-041859

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10170 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

|   |  |
|---|--|
| FILED OCT 31 1963   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>b. CITY (If outside corporate limits, give TOWNSHIP only)<br>c. FULL NAME OF (If NOT in hospital, give location HOSPITAL OR INSTITUTION)  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>b. COUNTY<br>c. CITY OR TOWN<br>d. STREET ADDRESS (If outside, give location) |
| a. COUNTY <u>St Louis</u><br>b. CITY <u>St Louis</u><br>c. FULL NAME <u>Homer R. Phillips</u>   | a. STATE <u>MO</u><br>b. COUNTY<br>c. CITY OR TOWN <u>St Louis</u><br>d. STREET ADDRESS <u>3103<sup>rd</sup> Bell</u>  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Hattie ANNE BELLE NERRING</u>  | 4. DATE OF DEATH<br>Month Day Year<br><u>10-10-63</u>  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Negro</u>   |
| 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>9-18-1880</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>   |
| 11a. BIRTHPLACE (City and state or country)<br><u>Nashville Tenn</u>  | 11b. CITIZEN OF WHAT COUNTRY<br><u>U.S.A</u>   |
| 13a. FATHER'S NAME<br><u>Tom Smith</u>  | 13b. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |
| 14. NAME OF HUSBAND OR WIFE<br><u>Deceased</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>NO</u>  | 16. SOCIAL SECURITY NO.<br>17. INFORMANT<br><u>Thomas Barton 3003<sup>rd</sup> Bell</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u><br>DUE TO (b) _____<br>DUE TO (c) <u>331x</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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, 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 _____ to _____ and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Joseph M. Quinn</u>  | 22b. ADDRESS<br><u>1900 Clark</u>  |
| 22c. DATE SIGNED<br><u>10-11-63</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   | 23b. DATE<br><u>10-14-63</u>   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>OAK Dale</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>Le May MO</u>  |
| 24. FUNERAL DIRECTOR<br><u>PRICE FUNERAL HOME 2829 Washington</u>   | 25. DATE RECD. BY LOCAL REG.<br><u>OCT 14 1963</u>   |
| 26. REGISTRAR'S SIGNATURE<br><u>Earl Smith, M.D.</u>  |  |



*Not used unless so ordered*

**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 *St Edward Flynn*

Licensed Embalmer No. *4444*

P. O. Address *St Louis*

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.