

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-045355**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

11958

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED DEC 12 1963

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Length of stay in 1b _____ c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CITY HOSPITAL #1</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1433 CLINTON</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>DONALD DAVIS</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>11 - 11 - 63</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>UNKNOWN</u>
<b>9. AGE</b> (last birthday) <u>31</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HANDY MAN</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>
<b>11. BIRTHPLACE</b> (City and state or country) <u>Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>UNKNOWN</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>	
<b>14. NAME OF HUSBAND OR WIFE</b> <u>UNKNOWN</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) _____	
<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <u>HELEN L. TAYLOR - CORONER - 1300 CLARK</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH _____
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
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY _____ STATE _____	
<b>21. I attended the deceased from _____ to _____ and last saw him alive on _____</b> Death occurred at <u>5:15 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> (Degree or title) <u>Helen L. Taylor, Coroner</u>		<b>22b. ADDRESS</b> <u>1300 Clark Ave.</u>	
<b>22c. DATE SIGNED</b> <u>11-14-63</u>		<b>23a. BIRTH, CREMATION, REMOVAL (Specify)</b> <u>St. Matthews Cem</u>	
<b>23b. DATE</b> <u>11-4-63</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Matthews Cem</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis Mo.</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Hoppe 4700 Washington</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>DEC 4 1963</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Road Smith, M.D.</u>

DO NOT WRITE ON THIS STUB  
 AMENDED  
 VS 300 Rev. 4/59  
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 ITEM NO.

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.

*Not Embalmed*  
*Leon H. C. Finbow*