

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049301

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12930** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
 1
 2 **205**
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 4 **3**
 5 **2**
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 7 **1**
 8 **1**
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 12 **913**
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91
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON

FILED JAN 9 1964

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA. CITY HOSP.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5948 Horton Place				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie First Buckley Last						4. DATE OF DEATH Month 12 Day 26 Year 63		8. DATE OF BIRTH 9-10-1913		9. AGE (last birthday) 50	
5. SEX F.		6. COLOR OR RACE NEGRO.		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) Miss.		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME EMMA DEAN MILLER				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 service)				16. SOCIAL SECURITY NO. -----		17. INFORMANT Emma Dean Miller		Address 5948 Horton Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Polar Pneumonia										INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										490x	
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 checked="" 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 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 _____ on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <i>Regina J. ...</i>						22b. ADDRESS 1300 Clay			22c. DATE SIGNED 12-28-63		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-31-63		23c. NAME OF CEMETERY OR CREMATORY Sunset Garden of Rest		23d. LOCATION (City, town, or county) (State) E. St. Louis, Illinois					
24. FUNERAL DIRECTOR Officer F. Home				25. DATE RECD. BY LOCAL REG. DEC 28 1963		26. REGISTRAR'S SIGNATURE <i>W. Smith, M.D.</i>					

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 James A. Hyatt

Licensed Embalmer No. 4441

P. O. Address 1389 Union

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.

RECEIVED
STATE BOARD OF HEALTH
MAY 15 1910