

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049339
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12277**

FILED DEC 20 1963

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| VS 300 | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT | DATE AMENDED |
| Rev. 4/59 | | |
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|---|---|---|--|
| 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) OR TOWN St. Louis, mo. | | c. CITY OR TOWN ST. LOUIS | |
| 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 St. Louis city Hosp. #1 | | d. STREET ADDRESS (If outside, give location) 3222 NO. NEWSTEAD | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) DONALD Baby Boy Cloudy | | | 4. DATE OF DEATH Month Nov Day 28 Year 1963 |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/28/63 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no | | 10b. KIND OF BUSINESS OR INDUSTRY none | 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours 1 23 |
| 11a. BIRTHPLACE (City and state or country) ST. LOUIS, MO | | 12. CITIZEN OF WHAT COUNTRY U.S.A | |
| 13a. FATHER'S NAME ALBERT ALEXANDER CLOUDY | | 13b. MOTHER'S MAIDEN NAME ROBERT JEAN MEADOWS | |
| 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) NO | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ST. LOUIS CITY HOSP. #1. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO (b) Congenital Atelectasis DUE TO (c) 762.5 | | 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 checked="" 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 a.m. 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., etc.) 11-28-63 | 20f. CITY, TOWN, OR LOCATION 11-28-63 COUNTY STATE |
| 21. I attended the deceased from Death occurred at 4:15 p.m. to 11-28-63 and last saw him alive on 11-28-63 | | her alive on | |
| 22a. SIGNATURE Alchabron (Degree or title) M.D. | | 22b. ADDRESS 1515 Lafayette Ave | 22c. DATE SIGNED 11-28-63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 12-31-63 | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
| 24. FUNERAL DIRECTOR ADDRESS MO. ANATOMICAL BOARD, 1402 S. GRAND | | 25. DATE RECD. BY LOCAL REG. DEC 12 1963 | 26. REGISTRAR'S SIGNATURE Loed Smith, M.D. |

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.