

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0051034
12574

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12574**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 16 1964

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

REMOVAL

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		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year		
5. SEX			6. COLOR OR RACE		
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>			8. DATE OF BIRTH		
9. AGE (last birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
11. BIRTHPLACE (City and State or Country)			12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		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 Address	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome</u> Generalized Arterio Sclerosis 4500 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 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.		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 _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title)			22b. ADDRESS		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR		ADDRESS		25. DATE RECD. BY LOCAL REG.	
26. REGISTRAR'S SIGNATURE					

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STATE
EMERALD

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 Arthur L. Hellbard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Ave

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.