

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

10820
State File No. 3214
Registrar's No.

FILED APR 12 1948 318

Primary Registration District No. 1003

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17
9
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1009 Brooklyn 9
26 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Haywood White

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Cal
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Quella White 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Feb 21 1891
(Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 7 If less than one day hr. _____ min. _____

9. Birthplace Lexington Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation Lab

11. Industry or business St Pauls Pharmacy

12. Name John White

13. Birthplace Lexington Tenn
(City, town, or county) (State or foreign country)

14. Maiden name Ida not known

15. Birthplace Lexington Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant Quella White

(b) Address 1009 Brooklyn

17. (a) Burial (b) Date thereof 4-3-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J.P. Gardner

(b) Address 2625 Glasgow

19. (a) APR 9 1948 (b) J.F. Bradeck
(Date received local health) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
year 1948 hour 10 minute 15 a. M.

21. I hereby certify that I attended the deceased from March 18, 1948 to March 28, 1948
that I last saw him alive on March 28, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis
Degenerative Heart Disease with
Decompensation

Duration
Undet.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury 0

23. Signature Order L Daniels (M. D. or other) _____

Address 2601 N. Whittier Date signed 3/29/48

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *AD Richardson*

Licensed Embalmer No. *2928*

P. O. Address: *city*

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 this body is not embalmed, fact should be so stated above.