

No. 300  
-10-47  
5-17-39  
P I 8906

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. **30931**  
Registrar's No. **7991**

Registration District No. **518** Primary Registration District No. **1005**

**1. PLACE OF DEATH:**  
(a) County **ST. LOUIS MISSOURI**  
(b) City or town **ST. LOUIS MISSOURI**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**HOMER Q. PHILLIPS HOSP.:**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

**3. (a) PRINT FULL NAME** **DAN CUBIT**  
**3. (b) If veteran,** name war **NONE** **3. (c) Social Security No.** **NONE**

**4. Sex** **MALE** **5. Color or race** **COL** **6. (a) Single, widowed, married, divorced** **Single**  
**6. (b) Name of husband or wife** **None** **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** **11 10 1883**  
(Month) (Day) (Year)

**8. AGE:** Years **64** Months **10** Days **20** If less than one day  
hr. min.

**9. Birthplace** **MO. BRIBE MISS.**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **NONE MISS.**

**11. Industry or business** **LABOR**

**12. Name** **JAMES CUBIT**

**13. Birthplace** **UNKNOWN MISS.**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **SALLIE WILLIAMS**

**15. Birthplace** **UNKNOWN MISS.**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **RUBIE MOORE**

**(b) Address** **4642 INDIAN CH**

**17. (a) Burial** (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

**(c) Place: burial or cremation** **ONKDALE CEMETERY**

**18. (a) Signature of funeral director** **Allen Doherty**

**(b) Address** **3506 FRANKLIN AVE**

**19. (a) SEP 13 1948** (b) **J. F. Breckner**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **17**  
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **9**  
(d) Street No. **222 1/2 Walnut St** (If rural, give location) **D**  
**22**  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Sept** day **10th**  
year **1948** hour **10:10** minute **A.** M.

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
**Coronary Thrombosis**  
Due to \_\_\_\_\_  
**94**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**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)  
(e) Means of injury \_\_\_\_\_

**23. Signature** **Allen Doherty** (M. D. or other)  
Address **3506 Franklin Ave** Date signed **9/14/48**

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

MOTHER FATHER

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**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 Leroy H. Bannister

Licensed Embalmer No. 4523

P. O. Address 3880 Eaton 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 this body is not embalmed, fact should be so stated above.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Dan cubic  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color B 6. (a) Single, widowed, married, divorced, single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Nov. 10 (Month) (Day) (Year)

8. AGE: Years 64 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Miss

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bressack (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

**SUPPLEMENTARY**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:  
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(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)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

S-30931

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