

U.S. Office of Vital Statistics
FILED DEC 31 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42129**
Registrar's No. **2542**

Registration District No. **317**

Primary Registration District No. **6576**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Wallerstein, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6210 Suburban Ave
(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 **SAMUEL 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 **Etta** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 17 1924**
(Month) (Day) (Year)

8. AGE: Years **74** Months **5** Days **21**
If less than one day _____ hr. _____ min.

9. Birthplace **New Brunswick Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Male**

11. Industry or business _____

12. Name **Chas. White**
13. Birthplace **New Brunswick Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Etta Charles**
15. Place of birth **What know** **A**
(City, town, or county) (State or foreign country)

16. (a) Informant **Etta White**
(b) Address **6210 Suburban**

17. (a) Burial (b) Date thereof **12-7-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **A. Richardson**
(b) Address **2625 Glasgow**

19. (a) 12-9-48 (Date received local registrar)
Richardson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **St. Louis**
(c) City or town **Wallerstein Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **6210 Suburban Ave**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **8**
year **1948** hour **10** minute **00 A.** M.
21. I hereby certify that I attended the deceased from Dec 5, 1948
1948 to **Dec 8**, 1948
that I last saw her alive on **Dec 5**, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Embolism **6 hours**
Due to **Hypertension** **unk**
Due to **836**

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 **0**

23. Signature **P. H. W. and** (M. D. or other) **MD**
Address **4848 E. Easton** Date signed **12/9/48**

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

6000

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 APJ Charles

Licensed Embalmer No. 2928

P. O. Address 2625 Glasgow

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.