

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2674

State File No. 876

BIRTH NO. 49-010004 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo b. COUNTY St. Louis

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri c. LENGTH OF STAY (in this place) 17 hrs.

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 17

d. FULL NAME OF HOSPITAL OR INSTITUTION The Peoples Hospital

d. STREET ADDRESS (If rural, give location) 4612 Washington

3. NAME OF DECEASED (Type or Print)
a. (First) Infant b. (Middle) _____ c. (Last) Flippings

4. DATE OF DEATH (Month) (Day) (Year) 1-12-49

5. SEX M 3

6. COLOR OR RACE col

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never

8. DATE OF BIRTH 1-11-49

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME George Flippings

13b. MOTHER'S MAIDEN NAME Jean Ella Anderson

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'S SIGNATURE OR NAME ADDRESS Jean Ella Flippings

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.

ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 11/11

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-11-49 to 1-12-, 1949, that I last saw the deceased alive on 1-12-, 1949 and that death occurred at 12:20 PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. B. Sasator

23b. ADDRESS 2607 1/2 Frank Ave

23c. DATE SIGNED 1-18-48

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE JAN 31 1949

24c. NAME OF CEMETERY OR CREMATORY Anatomical Board

24d. LOCATION (City, town, or county) (State)

DATE RECD BY LOCAL REG. JAN 31 1949

REGISTRAR'S SIGNATURE J. B. Sasator

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service 4104 Manchester Ave.

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

12

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.

Signed.....

Signed.....
Student Embalmer

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