

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6594  
State File No. 1627

318

1003

Registrar's No.

BIRTH NO.		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				b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS				c. LENGTH OF STAY (In this place)				c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips (I)				d. STREET ADDRESS (If rural, give location) 2967 Delmar Blvd (I)							
3. NAME OF DECEASED (Type or Print)		a. (First) William		b. (Middle) Rhodes		c. (Last) Rhodes		4. DATE OF DEATH (Month) (Day) (Year) Feb 17, 1949			
5. SEX M		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Feb 19, 1870		9. AGE (In years last birthday) 79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab or			10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (State or foreign country) Ala			12. CITIZEN OF WHAT COUNTRY? 1		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Ellen Rhodes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME Minnie Foster			ADDRESS 2809 E Delmar		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate (Post Oper.)				2. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Undetermined				Interval Between Onset and Death Undet.			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				3. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 2-8, 1949, to 2-17, 1949, that I last saw the deceased alive on 2-17, 1949, and that death occurred at 5:30 am., from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) Silas O. Binns M. D. (I)				23b. ADDRESS 2601 N Whittier				23c. DATE SIGNED 2/18/49			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Feb 21/49		24c. NAME OF CEMETERY OR CREMATORY Father Dickson		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.					
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 21 1949 J. B. Lasater				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. G. Green 4214 Delmar							

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

**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 \_\_\_\_\_

*F. L. Green*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2963

P. O. Address 4214 De la

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.