

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 10035
Registrar's No. 2395

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST., NO. 1003		Registrar's No. 2395			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 wks		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17			
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location): 3510 Coe Avenue					
3. NAME OF DECEASED (Type or Print) William Flood			a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Mar. 13 1949			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH 3/15/1900			
9. AGE (In years last birthday) 48		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Unknown			
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE Single			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rebecca Dunnegan					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Far-Advanced Pulmonary Tuberculosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Tuberculous Adenitis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None						INTERVAL BETWEEN ONSET AND DEATH	
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)		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 2-23, 1949, to 3-13, 1949, that I last saw the deceased alive on 3-13, 1949, and that death occurred at 1:45 Pm., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Oscar L Daniels M. D.				23b. ADDRESS 2601 N Whittier Wt		23c. DATE SIGNED 3-14-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/17/49		24c. NAME OF CEMETERY OR CREMATORY Oak Dale		24d. LOCATION (City, town, or county) (State) Lemay, Mo.			
DATE RECD BY REG. _____		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gene Deles - 3506 Franklin					

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

Signed

James J. [Signature]
Licensed Embalmer No. *4441*
P. O. Address *2829 [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.