

No. 300
10-48

FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17191
4721
Registrar's No.

BIRTH NO. 30473-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 8 hrs. 45		d. STREET ADDRESS (If rural, give location) 2517 Cora	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) <i>Infant</i> Davis			4. DATE OF DEATH (Month) (Day) (Year) 5 8 49		
5. SEX Male 2		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED	
8. DATE OF BIRTH 5-8-49		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?			

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) Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Joseph Davis		13b. MOTHER'S MAIDEN NAME Ethel Hoffman		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Ethel M. Sherman</i> 2601 N. Whittier			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		ANTECEDENT CAUSES					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		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				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) 159		21d. (STATE) 776X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		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 5-8-1949, to 5-8-1949, that I last saw the deceased alive on 5-8-1949, and that death occurred at 9:15a m., from the causes and on the date stated above.

23a. SIGNATURE <i>W. N. Quibles M.D.</i> (Degree or title)		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 5-11-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE MAY 31 1949		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG MAY 31 1949		REGISTRAR'S SIGNATURE <i>J. B. Pasater</i>		25. FUNERAL DIRECTOR'S NAME AND ADDRESS Rowland Mortuary Service 4104 Manchester Ave.			

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.