

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

20734
State File No. 4938

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 Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
c. LENGTH OF STAY (in this place)		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 12-4629 Washington	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Horace	b. (Middle) Edwards	c. (Last) Bacon	(Month) June	(Day) 5	(Year) 1949
5. SEX male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 11-27 1944	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 4
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) Miss.		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Eddie Bacon	13b. MOTHER'S MAIDEN NAME Hattie Lyons	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 1
(If yes, give war or dates of service)		ADDRESS

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		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Tuberculoma (Cerebral)		
	ANTECEDENT CAUSES DUE TO (b) Undetermined DUE TO (c)		
II. 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"/>
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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) 14
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? fall

22. I hereby certify that I attended the deceased from **5-31** **1949**, to **6-5**, **1949**, that I last saw the deceased alive on **6-5** **1949**, and that death occurred at **1:05a** m., from the causes and on the date stated above.

23a. SIGNATURE Allen E. Nash	(Degree or title) M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 6-6-49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6-9-49	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) St Louis, Mo
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DATE REC'D BY LOCAL REG. JUN 7 1949	REGISTRAR'S SIGNATURE L B Pasater	25. FUNERAL DIRECTOR'S SIGNATURE A. F. Walton	ADDRESS 2703 S. 1st
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WRITE PLAINLY—USING UNFADING 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.

Student
Student Embalmer

Signed Arthur L. Herliard

Licensed Embalmer No. 4221

P. O. Address 4049 St Ferdinand

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.