

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 9 1949

State File No. 20774

BIRTH NO. 36812-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5657

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 OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If rural, give location) 21-2325 Cole	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) b. (Middle) c. (Last) Infant Berry		5 28 49	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 5-27-49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months IF UNDER 12 HRS. Days IF UNDER 24 HRS. Mins
		11. BIRTHPLACE (State or foreign country) Missouri 0	
13a. FATHER'S NAME Separated		13b. MOTHER'S MAIDEN NAME Florida Wesman	
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 Katherine M. Howard, RRL 2601 N. Whittier	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intracranial Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES DUE TO (b) Birth Trauma			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
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) (STATE) New C	
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? 7:40	
22. I hereby certify that I attended the deceased from 5-27-49, 1949, to 5-28-49, 1949, that I last saw the deceased alive on 5-28-49, 1949, and that death occurred at 1:00am., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. H. Fischer, M.D.		23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 6-1-49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JUN 30 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REG. JUN 30 1949	REGISTRAR'S SIGNATURE J. B. Pasater	25. FUNERAL DIRECTOR'S SIGNATURE 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.