

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 7 1949

State File No. 31778
Registrar's No. 8187

BIRTH NO. _____ 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 Mo b. COUNTY St. Lo	
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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 21 2935 DAYTON 90	
3. NAME OF DECEASED a. (First) Robert		b. (Middle) Gayten	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Sept. 18 1949	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH MAY 18, 1887
9. AGE (In years last birthday) 62		10. UNDER 1 YEAR Months 2	
11. UNDER 1 HR. Hours 1		12. UNDER 15 HR. Hours 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ? MISS		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME UNK.		13b. MOTHER'S MAIDEN NAME UNK.	
14. NAME OF HUSBAND OR WIFE NONE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Berta Banks		ADDRESS 2935 DAYTON	
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) Arteriosclerotic Heart Disease 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"/>			
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) 935			
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? H.S.			
22. I hereby certify that I attended the deceased from 9-16, 1949, to 9-18, 1949, that I last saw the deceased alive on 9-18, 1949, and that death occurred at 11:20 p.m., from the causes and on the date stated above.			
23a. SIGNATURE James J. Sedwick M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 9-20-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Sept 24, 1949	
24c. NAME OF CEMETERY OR CREMATORY Washington Pk.		24d. LOCATION (City, town, or county) (State) St. Louis MO	
DATE REC'D BY LOCAL REG. SEP 22 1949		REGISTRAR'S SIGNATURE JB Laster	
25. FUNERAL DIRECTOR'S SIGNATURE English Und. Co		ADDRESS 2931 Locas	

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 Burlison English
.....

Licensed Embalmer No. 4208

P. O. Address 2931 Lucas, W.V.

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.