

FILED APR 9 1951

STANDARD CERTIFICATE OF DEATH

10791
State File No. 2253
REG. DIST. NO. 318
PRIMARY REG. DIST. NO. 1003
Registrar's No.

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) 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 Phillips Hospital		9. STREET ADDRESS (If rural, give location) 5336 Bulwer St.	

3. NAME OF DECEASED (Type or Print) a. (First) Lela b. (Middle) Joe c. (Last) White			4. DATE OF DEATH (Month) (Day) (Year) March 7, 1951			
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 7	8. DATE OF BIRTH December 25, 1949	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME William White		13b. MOTHER'S MAIDEN NAME Rosa Lee Hughes		14. NAME OF HUSBAND OR WIFE none	
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rosa Lee White 5336 Bulwer St.	

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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Congenital Atrophy of Brain</i> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		21f. HOW DID INJURY OCCUR? 752.1	
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"/>					

22. I hereby certify that I attended the deceased from _____ 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:55 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Walter H. Bennister</i> 3		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 3/10/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 12, 1951		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 10 1951 <i>J. B. Foster</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Walter H. Bennister</i> 3880 Easton Ave.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

530

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 Leroy H. Pannicter

Licensed Embalmer No. 4523

P. O. Address 3880 Easton Ave

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.