

No. 300
10. 48

APR 25 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14310**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3319**

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		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2199		
d. FULL NAME OF HOSPITAL OR INSTITUTION P.O.F. Homer G Phillips			d. STREET ADDRESS (If rural, give location) 19 3957 Delmar Blvd		
3. NAME OF DECEASED (Type or Print) Monteil		a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) April 8 1952
5. SEX F 3	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH Feb 29 1952	9. AGE (In years last birthday) 1 9 if UNDER 1 YEAR Months Days if UNDER 24 Hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) St. Louis, Mo 0	12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME Earl Graham		13b. MOTHER'S MAIDEN NAME Dorothy Carroll		14. NAME OF HUSBAND OR WIFE -	
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. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Earl Graham 3957 Delmar Blvd	
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, ashenia, 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) Interstitial Pneumonitis 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 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)	
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?	
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 5:43 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE <i>[Signature]</i>			23b. ADDRESS 1300 Clark Avenue		23c. DATE SIGNED 4/9/52
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE April 9 1952	24c. NAME OF CEMETERY OR CREMATORY Greenwood		24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.
DATE REC'D BY LOCAL APR 9 1952		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.H. Randle & Son 3133 Bell Ave	

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....
working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.
Not Embalmed
Signed *Edw. N. Randlee*

Licensed Embalmer No.

P. O. Address *3133 Bell Av.*

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.