No. 300
10.46

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUL 31 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26477

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7017

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 69 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G. Phillips

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 22nd
d. STREET ADDRESS (If rural, give location): 2262 Clark ave

3. NAME OF DECEASED (Type or Print)
a. (First): Rev.
b. (Middle): Adolph C.
c. (Last): White

4. DATE OF DEATH (Month) 7 (Day) 16 (Year) 52

5. SEX: M
6. COLOR OR RACE: Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5-4-1883
9. AGE (In years last birthday): 69 — 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): Retired Preacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Fredricks Town Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: June Nipong
14. NAME OF HUSBAND OR WIFE: Palestine White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Palestine White Cubis City Ill Esc

MEDICAL CERTIFICATION

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Myocarditis
DUE TO (c) decompensated

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 ☑ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

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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 2:45 P. m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Patrick C. Taylor Coroner 3
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 7-21-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Bu
24b. DATE: 7-21-52
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St. Louis Co. Mo

DATE REC'D BY LOCAL REG.: JUL 21 1952
REGISTRAR'S SIGNATURE: J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Gus Lowe 2934 Dickson
(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 _____

_____; Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Leroy U. Sammiter

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.