

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

AUG 28 1952

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7492**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 2219	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 0	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) St Louis	d. STREET ADDRESS (If rural, give location) 1010 N. Leffingwell
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		21	

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) c. (Last) Douglas	4. DATE OF DEATH (Month) (Day) (Year) August 4, 1952
-----------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------

5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED - 3	8. DATE OF BIRTH Dec. 28, 1923	9. AGE (In years) (last birthday) 28	10. UNDER 1 YEAR 7	11. UNDER 1 MIN. 7
--------------------	---------------------------------	-------------------------------------------------------------------------------	------------------------------------------	------------------------------------------------	------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY AMER. CAR	11. BIRTHPLACE (State or foreign country) CANTON, MISSISSIPPI	12. CITIZEN OF WHAT COUNTRY?
---------------------------------------------------------------------------------------------------------------	-------------------------------------------------------	-------------------------------------------------------------------------	------------------------------

13. FATHER'S NAME Percy Douglas	13b. MOTHER'S MAIDEN NAME Bessie Watkins	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.	17. INFORMANT'S SIGNATURE OR NAME Mrs Bessie Dean	ADDRESS 2718 Cole St
-----------------------------------------------------------------------------------------------------------------------	-------------------------	-------------------------------------------------------------	--------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Right Pleural Effusion (T.B.C.)		Undetermined
ANTECEDENT CAUSES	DUE TO (b) Probable Tubercular Meningitis		"
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

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"/>	21f. HOW DID INJURY OCCUR? 010X
--------------------------------------------------------	--------------------------------------------------------------------------------------------------------	-------------------------------------------

22. I hereby certify that I attended the deceased from **July 22, 1952**, to **Aug. 4, 1952**, that I last saw the deceased alive on **AUG. 4, 1952** and that death occurred at **7:05 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Edua E. Brooks	(Degree or title) M.D.S.	23b. ADDRESS 2601 N. Whittier St.	23c. DATE SIGNED August 4, 1952
-----------------------------------------	------------------------------------	---------------------------------------------	-------------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8-9-52	24c. NAME OF CEMETERY OR CREMATORY GREENWOOD cem	24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO
------------------------------------------------------------	----------------------------	------------------------------------------------------------	--------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. AUG 6 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON	ADDRESS 2707 STODDARD ST
-----------------------------------------------	-----------------------------------------------	--------------------------------------------------------	------------------------------------

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

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 Embalmer No.....

Signed.....

Arthur L. Holliard

Signed.....

Student Embalmer

Licensed Embalmer No. *4221*

P. O. Address *4524 Aldine*

Notes: 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.