

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 21 1952

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>9127</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (In this place township) <u>25 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> <u>2192</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>4049 Washington Avenue</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Melvin</u> b. (Middle) _____ c. (Last) <u>Singleton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 29, 1952</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>March 5, 1916</u>		9. AGE (In years last birthday) <u>36</u>		10. MONTHS <u>6</u>	11. DAYS <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Collinsville, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Hazel Singleton</u>		13b. MOTHER'S MAIDEN NAME <u>Edna Jackson</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hazel Singleton, 4061 Enright Ave.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Left Lower Lobe Bronchiectasis</u> ANTECEDENT CAUSES DUE TO (b) <u>Undetermined</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
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? <u>526 X</u>					
22. I hereby certify that I attended the deceased from <u>9-27</u> , 19 <u>52</u> to <u>9-29</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>9-29</u> , 19 <u>52</u> , and that death occurred at <u>9:30pm.</u> , from the causes and on the date stated above.							
23. SIGNATURE (Degree or title) <u>Charles J. Gates, M. D.</u>				23b. ADDRESS <u>2601 N Whittier St.</u>		23c. DATE SIGNED <u>9-30-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10/4/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>OCT 2 1952</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles J. Gates, 4107 Finney Ave.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

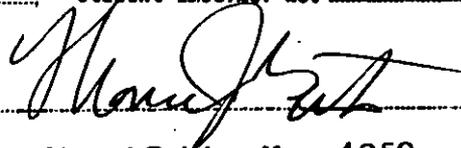
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.