

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 26 1954

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1003

State File No. 2793  
Registrar's No. 0279

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
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 town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2229 Market St</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) _____ c. (Last) <u>Garrett</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 6, 1954</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED/ WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Aug. 1, 1899</u>			
9. AGE (In years last birthday) <u>54</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed for years</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		9. AGE (In years last birthday) Months _____ Days _____			
11. BIRTHPLACE (City and State or Foreign Country) <u>Robertsville, Mississippi</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13a. FATHER'S NAME <u>Frank Garrett</u>			13b. MOTHER'S MAIDEN NAME <u>Betty Martin</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Minnie Clemons</u> ADDRESS <u>2349 Spruce</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic Epidermoid Carcinoma of the Neck (primary site undet.)</u>				ANTECEDENT CAUSES					
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____					
DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death. <u>Malnutrition</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) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____ <u>1991</u>					
22. I hereby certify that I attended the deceased from <u>9-24</u> , 19 <u>53</u> , to <u>1-6</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>1-5</u> , 19 <u>54</u> , and that death occurred at <u>5 p</u> m., from the causes and on the date stated above.									
23. SIGNATURE (Degree or title) <u>Carl Phillips M. D.</u>				23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>1-7-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-14-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>JAN 11 1954</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Metropolitan Funeral System Inc.</u> ADDRESS <u>5010 Enright Ave.</u>					

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 .....  
Signature of Student Embalmer

Signed *Paul V. Freeman* .....

Licensed Embalmer No. *46* .....

P. O. Address *4729* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.