

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6625

State File No.

BIRTH NO. FILED MAR 8 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1869

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 St. Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS: (If rural, give location) 3644 Finney	

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Allen c. (Last) North			4. DATE OF DEATH (Month) (Day) (Year) 2 24 54		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 9/25 - 1891	9. AGE (In years last birthday) 62	# UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY unemployed	11. BIRTHPLACE (City and State or Foreign Country) Ducon, Illinois		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME David North	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE - - -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 491-12-617	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Georgia North - 4149 Washington Ave.
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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		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Middle Lobar Pneumonia		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 490X
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22. I hereby certify that I attended the deceased from 2-23, 1954, to 2-24, 1954, that I last saw the deceased alive on 2-24, 1954, and that death occurred at 5:25 Pm., from the causes and on the date stated above.

23a. SIGNATURE E. B. Williams (Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 2-25-54
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE March 1, 1954	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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DATE REC'D BY LOCAL REG. FEB 27 1954	REGISTRAR'S SIGNATURE J. Earl Smith Md	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Atkins Bros. Und. Co. 3644 Finney
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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 *John K. Cunningham*.....

Licensed Embalmer No. 4476

P. O. Address 4700 Hammett

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.