

20293

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

5576

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

|  |                             |  |  |   |   |
|--|-----------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                             |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY _____ |   |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR 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 checked="" type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Homer G. Phillips Hospital</u>   |                             |  | e. STREET ADDRESS (If rural, give location) <u>2718 Spruce</u>   |   |   |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Joyce Carson</u>   |                             |  | a. (First) _____   | b. (Middle) _____   | c. (Last) _____   |
| 4. DATE OF DEATH (Month) (Day) (Year) <u>6 17 54</u>   |                             |  |  |   |   |
| 5. SEX <u>Fem 3</u>  | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____   | 8. DATE OF BIRTH <u>June 16, 1953</u>  | 9. AGE (In years last birthday) <u>1</u>  | 10. UNDER 1 YEAR: Months _____ Days _____<br>11. UNDER 1 MIN. Hours _____ Mins. _____   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____  |                             | 10b. KIND OF BUSINESS OR INDUSTRY _____  | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>  |   | 12. CITIZEN OF WHAT COUNTRY? _____  |
| 13a. FATHER'S NAME <u>Kelly Carson</u>   |                             | 13b. MOTHER'S MAIDEN NAME <u>InElla Sullivan</u>   |  | 14. NAME OF HUSBAND OR WIFE _____   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____  |                             | 16. SOCIAL SECURITY NO. _____  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>InElla Carson, 2718 Spruce Street</u>   |   |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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>Pneumonia - Staphylococcal Meningitis</u>  |                             |  | INTERVAL BETWEEN ONSET AND DEATH <u>Undt.</u>  |   |   |
| ANTECEDENT CAUSES  |                             |  | DUE TO (b) _____   |   |   |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.   |                             |  | DUE TO (c) _____   |   |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>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) <u>340.2</u>   |   |   |
| 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? _____   |   |   |
| 22. I hereby certify that I attended the deceased from <u>6-10</u> , 19 <u>54</u> , to <u>6-17</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>6-17</u> , 19 <u>54</u> , and that death occurred at <u>1:30P</u> m., from the causes and on the date stated above. |                             |  |  |   |   |
| 23a. SIGNATURE (Degree or title) <u>Helen Nash, M.D. C.</u>  |                             |  | 23b. ADDRESS <u>2601 N. Whittier</u>   |   | 23c. DATE SIGNED <u>6-18-54</u>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   | 24b. DATE <u>6/23/54</u>    | 24c. NAME OF CEMETERY OR CREMATORY <u>Booker T. Washington</u>   | 24d. LOCATION (City, town, or county) (State) <u>E. St. Louis, Ill</u>   |   |   |
| DATE REC'D BY LOCAL REG. <u>JUN 22 1954</u>  |                             | REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. M. C. Green, 4060 Washington Ave</u> |   |

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
*Melvin E. Green*

Licensed Embalmer No. *442*

P. O. Address *St. Louis*

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.