

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28901

7632

Registrar's No. 1003

BIRTH NO. _____		REG. DIST. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1003			
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. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 12 4814 Fountain				2129	
3. NAME OF DECEASED (Type or Print) a. (First) Douglas			b. (Middle) _____		c. (Last) Gartrell		4. DATE OF DEATH (Month) 8 (Day) 17 (Year) 54		
5. SEX Male		6. COLOR (OR RACE) Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Bachelor		8. DATE OF BIRTH Sep 13-1969		9. AGE (In years last birthday) 84 Months 11 Days 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and State or Foreign Country) Little Rock Ark.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Cecel Gartrell			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Bachelor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 497-166044		17. INFORMANT'S SIGNATURE OR NAME Mrs. A.B. Gladney			ADDRESS 4814 Fountain		
18. CAUSE OF DEATH—Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Malnutrition Stage Cachexia				INTERVAL BETWEEN ONSET AND DEATH Undt.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				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. Pulmonary Emphysema					
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 2865					
22. I hereby certify that I attended the deceased from 8-15 ¹⁹⁵⁴ , to 8-17 ¹⁹⁵⁴ , that I last saw the deceased alive on 8-17 ¹⁹⁵⁴ , and that death occurred at 6:50A m., from the causes and on the date stated above.									
23a. SIGNATURE Hugh Waters				(Degree or title) M.D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 8-17-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 8-19-1954		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem'		24d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State) _____	
DATE REC'D BY LOCAL REG. AUG 18 1954		REGISTRAR'S SIGNATURE J. Earl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Moses Adams ADDRESS 3849 Windsor Place				

25. (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.....
Signature of Student Embalmer

Signed *F. A. Green*.....

Licensed Embalmer No. *296*.....

P. O. Address *4214 Delm*.....

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.