

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28933
State File No. 7463

318

1003

7463

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 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 type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>3618 Evans</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>None</u> c. (Last) <u>Guest</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 5, 1954</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Am. Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 10, 1917</u>	
9. AGE (In years last birthday) <u>37</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hour _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Senatuba, Miss.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>EUGENE GUEST</u>			13b. MOTHER'S MAIDEN NAME <u>MINNIE FOSTER</u>			14. NAME OF HUSBAND OR WIFE <u>LOTTIE GUEST</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>477-12 2452-2</u>		17. INFORMANT'S SIGNATURE OR NAME <u>LOTTIE GUEST</u>		ADDRESS <u>3618 Evans</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>Pneumonia, Fatty Metamorphosis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undt</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? <u>493x</u>			
22. I hereby certify that I attended the deceased from <u>June 12, 1954</u> , to <u>August 5, 1954</u> that I last saw the deceased alive on <u>August 5, 1954</u> , and that death occurred at <u>8:30 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Carl Belle Smith M.D.</u>				23b. ADDRESS <u>2601 N. Whittier</u>		23c. DATE SIGNED <u>8/9/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Aug. 11, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>SENATUBIA MISS.</u>	
DATE REC'D BY LOCAL REG. <u>AUG 11 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Belle Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. ... 2405 Marcus</u> ADDRESS _____			

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

SEP 2 1954

SEP 14 1954

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. *447*.....

P. O. Address

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.