

FILED NOV 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35957

BIRTH NO. 74499-54

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

State File No. ....

Registrar's No. 9527

|   |                           |  |                                       |
|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE<br>Missouri<br>b. COUNTY   |                                       |
| b. CITY (If outside corporate limits, write RURAL and give town)<br>St Louis  |                           | c. CITY (If outside corporate limits, write RURAL and give township)<br>St Louis   |                                       |
| c. LENGTH OF STAY (In this place)   |                           | d. STREET ADDRESS (If rural, give location)<br>5 5222 Vernon Avenue 2059   |                                       |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>Saint Louis Maternity  |                           |  |                                       |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First)<br>b. (Middle)<br>c. (Last)<br>Sexton  |                           | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br>September 25 1954  |                                       |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>--   | 8. DATE OF BIRTH<br>September 25 1954 |
| 9. AGE (In years last birthday)<br>10. MONTHS<br>11. DAYS<br>2 20   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>--   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>--   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>--  |                                       |
| 11. BIRTHPLACE (City and State or Foreign Country)<br>St Louis Missouri   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>--   |                                       |
| 13a. FATHER'S NAME  |                           | 13b. MOTHER'S MAIDEN NAME<br>Katherine Inez Mc Ginnis  |                                       |
| 14. NAME OF HUSBAND OR WIFE   |                           |  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>--  |                           | 16. SOCIAL SECURITY NO.<br>--  |                                       |
| 17. INFORMANT'S SIGNATURE OR NAME<br>Katherine Inez Sexton  |                           | ADDRESS<br>5222 Vernon Ave.  |                                       |
| 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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>not determined</i><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <i>premature development 930 gm.</i><br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <i>none known</i> |                                       |
| 19a. DATE OF OPERATION  |                           | 19b. MAJOR FINDINGS OF OPERATION<br><i>normal vaginal delivery</i>   |                                       |
| 20. AUTOPSY?<br>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   |                           | 776X   |                                       |
| 22. I hereby certify that I attended the deceased from <u>Sept 25</u> 19 <u>54</u> , to <u>Sept 25</u> 19 <u>54</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>54</u> , and that death occurred at <u>8:35 A.</u> , from the causes and on the date stated above. |                           |  |                                       |
| 23a. SIGNATURE<br><i>Samuel E. Mage</i>   |                           | 23b. ADDRESS<br><i>630 S. Kingshighway Blvd.</i>   |                                       |
| 23c. DATE SIGNED<br><i>10-9-54</i>  |                           |  |                                       |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)   |                           | 24b. DATE<br><i>10-30-54</i>   |                                       |
| 24c. NAME OF CEMETERY OR CREMATORY<br><i>Anatomical Board</i>   |                           | 24d. LOCATION (City, town, or county) (State)<br><i>St. Louis, Mo.</i>   |                                       |
| DATE REC'D BY LOCAL REG.<br>OCT 20 1954   |                           | REGISTRAR'S SIGNATURE<br><i>J. Carl Smith MD Rowland - Aker 4401 Manchester</i>  |                                       |
| 25. FUNERAL DIRECTOR'S SIGNATURE  |                           | ADDRESS<br><i>4401 Manchester</i>  |                                       |

(Licensed Embalmers' Signature on Reverse Side)

**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 .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.