

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 18 1955

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State File No. 43915
Registrar's No. 11892

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>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) (township) <u>2yr 6mo</u>		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>St. Louis Chronic Hospital.</u>				e. STREET ADDRESS (If rural, give location) <u>2139 13 5800 Arsenal St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sherman</u>		b. (Middle) _____		c. (Last) <u>Pool</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 24, 1954</u>	
5. SEX <u>male</u>		6. COLOR (R RACE) <u>colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>Jan. 1, 1881</u>	
9. AGE (In years last birthday) <u>73</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Ala.</u>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>Ben Pool</u>		13b. MOTHER'S MAIDEN NAME <u>Allie ??</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>MR BRADY Public Administrator</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>Central spinal system Les</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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>026x</u>					
22. I hereby certify that I attended the deceased from <u>June 24, 1952</u> , to <u>December 24, 1954</u> , that I last saw the deceased alive on <u>December 24, 1954</u> , and that death occurred at <u>15 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE (Degree or title) <u>Salum Dorian Powell M.D.</u>				23b. ADDRESS <u>5800 Arsenal St.</u>		23c. DATE SIGNED <u>12-24-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>12-29-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>DAK DALE</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO.</u>	
DATE REC'D BY LOCAL REG. <u>DEC 29 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bennie Love 3103 Washington</u>			

WRITE PLAINLY—USING UNFAADING 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 *No Embalming*
James Earl Smith
Licensed Embalmer No.....

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.