

FILED JAN 18 1955

STANDARD CERTIFICATE OF DEATH

State File No. **44063**

BIRTH NO. **83973-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **12037**

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE<br><b>Missouri</b><br>b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b>  |  |
| c. LENGTH OF STAY (in this place)<br><b>2 mo. 5 days</b>                                 |  | d. STREET ADDRESS (If rural, give location)<br><b>1815 N. Garrison</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Homer G. Phillips</b>                      |  |   |  |

|   |  |                                       |  |  |  |  |  |
|---|--|---------------------------------------|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br><b>Donald</b> |  | b. (Middle)<br><b>(Twin # 1)</b>      |  | c. (Last)<br><b>Theford</b>  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>12 21 54</b>                                |  |
| 5. SEX<br><b>Male</b>                                   |  | 6. COLOR OR RACE<br><b>Negro</b>      |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>0</b> |  | 8. DATE OF BIRTH<br><b>10-17-54</b>  |  |
| 9. AGE (In years last birthday)<br><b>2</b>             |  | IF UNDER 1 YEAR<br>Months<br><b>2</b> |  | IF UNDER 12 HRS.<br>Days<br><b>5</b>                               |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |
| 10a.  |  | 10b. KIND OF BUSINESS OR INDUSTRY     |  | 11. BIRTHPLACE (State or foreign country)<br><b>Missouri</b>       |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>0</b>   |  |

|   |  |  |  |                             |  |
|---|--|--|--|-----------------------------|--|
| 13a. FATHER'S NAME<br><b>John Theford</b> |  | 13b. MOTHER'S MAIDEN NAME<br><b>Bertha Jackson</b> |  | 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<br><i>Arthur M. Sheward</i> |  | ADDRESS<br><b>CRL 2601 N. Whittier</b> |  |
|---|--|-------------------------|--|---|--|--|--|

|  |  |                                      |  |  |  |                                  |  |
|--|--|--------------------------------------|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION                |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Diarrhea</b>   |  | DUE TO (b) <b>Cause undetermined</b> |  |  |  |                                  |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                               |  | DUE TO (c)                           |  |  |  |                                  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Premature birth, Neonatal death</b> |  |                                      |  |  |  |                                  |  |

|                        |  |                                  |  |   |  |
|------------------------|--|----------------------------------|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  | 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) (Min.) |  | 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 **10-17**, 19**54**, to **12-21**, 19**54**, that I last saw the deceased alive on **12-21**, 19**54** and that death occurred at **12:21 P.M.**, from the causes and on the date stated above.

|   |  |                                  |  |   |  |                                     |  |
|---|--|----------------------------------|--|---|--|-------------------------------------|--|
| 23a. SIGNATURE<br><i>William H. Linkler</i> |  | (Degree or title)<br><b>M.D.</b> |  | 23b. ADDRESS<br><b>2601 N. Whittier</b> |  | 23c. DATE SIGNED<br><b>12-22-54</b> |  |
|---|--|----------------------------------|--|---|--|-------------------------------------|--|

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) |  | 24b. DATE<br><b>1-31-55</b> |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomical Board</b> |  | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b> |  |
|---|--|-----------------------------|--|---|--|--|--|

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG.<br><b>JAN 11 1955</b> |  | REGISTRAR'S SIGNATURE<br><i>Carl Smith</i> |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><i>Rowland</i> |  | ADDRESS<br><b>4104 Manchester Ave.</b> |  |
|--|--|--|--|--|--|--|--|

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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 .....  
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 comply with the above constitutes grounds for revocation of license.)**

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