

STANDARD CERTIFICATE OF DEATH

FILED AUG 15 1955

State File No. **24430**
Registrar's No. **6351**

BIRTH NO. **61097-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1009**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) STAY	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homér G. Phillips Hosp.		d. STREET ADDRESS (If rural, give location) 4134 Finney	
3. NAME OF DECEASED (Type or Print) a. (First) Darrel b. (Middle) Robert c. (Last) Stokes		4. DATE OF DEATH (Month) (Day) (Year) 7 21 55	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH 7-19-55
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) IF UNDER 1 Year IF UNDER 24 Hrs. Min.	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Missouri, St. Louis		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Gladys Stokes	
14. NAME OF HUSBAND OR WIFE		17. INFORMANT'S SIGNATURE OR NAME Mrs. E. M. Sheard, C.R.L.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO.	
17. ADDRESS 2601 N. Whittier		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7600	
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?	
22. I hereby certify that I attended the deceased from 7-19 , 19 55 , to 7-21 , 19 55 , that I last saw the deceased alive on 7-21 , 19 55 , and that death occurred at 9:40p.m. , from the causes and on the date stated above.			
23a. SIGNATURE William H. Sinkler, M.D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 7-23-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) REM	24b. DATE 7-23	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
DATE REC'D BY LOCAL REG. JUL 23 1955	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Manuel Undertaking	
		ADDRESS 4059 Finney	

f.p. (Licensed Embalmer's Statement 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 _____

Not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Manuel Sadt

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.