

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 26 1956

State File No. **3099**  
Registrar's No. **557**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>557</b>		
1. PLACE OF DEATH a. COUNTY <u>St. Louis-Missouri</u>				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 _____		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>1933 Belleglade</u>				e. STREET ADDRESS (If rural, give location) <u>11 1933 Belleglade</u> <span style="float: right;">21190</span>				
3. NAME OF DECEASED (Type or Print) <u>Alphonse Alphonse</u>			a. (First) _____		b. (Middle) _____		c. (Last) <u>Whitfield</u>	
4. DATE OF DEATH <u>Jan 14 1956</u>		(Month) (Day) (Year)		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>23 rd April 1885</u>		9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Troy Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>		
13a. FATHER'S NAME <u>Dr Charles Bragg</u>		13b. MOTHER'S MAIDEN NAME <u>Alphonse Bragg</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Whitfield</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr Charles Whitfield</u> ADDRESS <u>1933 Belleglade</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebro Vasculat Accident</u> ANTECEDENT CAUSES DUE TO (b) <u>Arterio Sclerosis E</u> DUE TO (c) <u>Hypertension</u> 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 _____		20. AUTOPSY? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>		3314		
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) _____		21f. HOW DID INJURY OCCUR? _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>May 1950</u> , to <u>1-14-1956</u> , that I last saw the deceased alive on <u>1-14-1956</u> , and that death occurred at <u>12:40 p. m.</u> , from the causes and on the date stated above.				
23a. SIGNATURE <u>Russell H. White, M.D.</u> (Degree or title)		23b. ADDRESS <u>2424 E. N. Sarah</u>		23c. DATE SIGNED <u>1/16/56</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1/18/56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Peters CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>Lucas &amp; Hunt Rd MO</u>		
DATE REC'D BY LOCAL REG. <u>JAN 17 1956</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman J. Smith</u> ADDRESS <u>4247/w Labadie</u>				

WRITE PLAINLY—USING UNFADING 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 *W. Claude Gowan*.....

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*.....

**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.**