

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28911

State File No.

1003 Registrar's No. 7757

FILED SEP 6 1956
BIRTH NO. 65268-56

REG. DIST. NO. 318

PRIMARY REG. DIST. NO.

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			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St Louis)		c. LENGTH OF STAY (in this place) c. CITY OR TOWN St Louis		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 Saint Louis Maternity		STREET ADDRESS (If rural, give location) 21 1103 North Leonard 221/2			
3. NAME OF DECEASED (Type or Print) a. (First)		b. (Middle)		c. (Last)	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH July 25 1956		9. AGE (In years last birthday)		4. DATE OF DEATH (Month) (Day) (Year) August 7 1956	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri	
13a. FATHER'S NAME Hubert Nicholson		13b. MOTHER'S MAIDEN NAME Aretha Bonner		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 Aretha Nicholson Above	
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) Period of gestation, incomplete with life. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 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 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?	
22. I hereby certify that I attended the deceased from July 25 1956 , to Aug 7 1956 , that I last saw the deceased alive on Aug 7 1956 , and that death occurred at 3:00 A. , from the causes and on the date stated above.					
23a. SIGNATURE Thomas K. Murchany M.D. (Degree or title)		23b. ADDRESS St. L. Maternity Hosp		23c. DATE SIGNED 8-7-56	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 8-31-56		24c. NAME OF CEMETERY OR CREMATORY Anatomical Buro	
				24d. LOCATION (City, town, or county) (State) St. Louis, MO.	
DATE REC'D BY LOCAL REG. AUG 21 1956		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 4104-06 Manchester Rowland Mortuary Svc.	

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.....

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.