

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 25 1957

10614-57

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

6524

1226

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR. TOWN ST. LOUIS				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1.				Length of stay in lb 2239		d. STREET ADDRESS 2004 1/2 SO. 3rd.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDIANNE Middle EEL Last PHILLIPS						4. DATE OF DEATH FEB. 2, 1957 Month Day Year							
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/57		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hrs. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES PHILLIPS						14. MOTHER'S MAIDEN NAME FLORENCE CAVEN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT ST. LOUIS CITY HOSP. RECORDS #1. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumptive death functioning prematurely Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 776x									
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION				COUNTY		STATE	
21. I attended the deceased on 2/2/57 at 8:25 A.M. to 2/2/57 and last saw her alive on 2/2/57 . Death occurred at 8:25 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>William T. Peterson, M.D.</i>						22b. ADDRESS 1515 LAFAYETTE AVE.				22c. DATE SIGNED 2/1/57			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-28-57		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board				23d. LOCATION (City, town, or county) (State) St. Louis, Mo.					
24. FUNERAL DIRECTOR Rowland - Skov 4104 Manchester ADDRESS				25. DATE RECD. BY LOCAL REG. FEB 7 '57				26. REGISTRAR'S SIGNATURE <i>Carl Smith MO 286</i>					

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. (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.