

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15454

FILED APR 26 1957

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3594**

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 <b>MISSOURI</b> b. COUNTY		
b. CITY OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>ST. LOUIS</b>		d. STREET ADDRESS (If rural, give location)
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>27 HOMER G. Phillips Hosp</b>			d. STREET ADDRESS <b>2110 2937<sup>2</sup> SHERIDAN AVE.</b>		
3. NAME OF DECEASED (Type or Print) <b>EUGENE</b>		a. (First)	b. (Middle)	c. (Last) <b>White</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>4-11-57</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-14-1898</b>	9. AGE (In years last birthday) <b>58 yrs</b>	10. UNDER 1 YEAR (Month) (Day) (Hour) (Min.) <b>9 28</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CAB DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TAXI CAB</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>PINE BLUFF, ARK.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13a. FATHER'S NAME <b>John White</b>		13b. MOTHER'S MAIDEN NAME <b>MARTHA CARTER</b>		14. NAME OF HUSBAND OR WIFE <b>CAROLINE WHITE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Caroline White 2916 TAYLOR</b>		
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) <b>Pulmonary Embolism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4-6-57</b>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Congestive Heart Failure</b>			3-28-57		
DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>			Nov. 1956		
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 <b>443x</b>			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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 <b>4-6, 1957</b> , to <b>4-11, 1957</b> , that I last saw the deceased alive on <b>4-11, 1957</b> , and that death occurred at <b>10:45 P.M.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>J. L. Shewell, M.D.</b>			23b. ADDRESS <b>2708 Franklin</b>		23c. DATE SIGNED <b>4-12-57</b>
24a. BURIAL, CREMATION REMOVAL (Specify) <b>REMOVAL</b>	24b. DATE <b>4-16-57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD CEM.</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, CTY MO</b>	
DATE REC'D BY LOCAL REG. <b>APR 15 57</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MO</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>A. F. WALTON 2707 STODDARD</b>	

MFB (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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.