

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33398

FILED OCT 4 1957

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 9051

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, 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 Homer G. Phillips			Length of stay in 1b	d. STREET ADDRESS 920 No. 16th (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Albert Middle Dean Last Dean			4. DATE OF DEATH	Month 9 Day 24 Year 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) HOMER, TENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME ALFRED DEAN			14. MOTHER'S MAIDEN NAME CAROLINE WILLIAMS		
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. UNKNOWN	17. INFORMANT Address Julia M. Beach 923 N 19th St		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriolar nephrosclerosis					INTERVAL BETWEEN ONSET AND DEATH: undet.
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.)		
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 from 9-21-57 to 9-24-57 and last saw him ^{her} alive on 9-24-57 Death occurred at 4:00 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Sweeney Fowler, M.D.			22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 9-27-57
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-30-57	23c. NAME OF CEMETERY OR CREMATORY OAKDALE CEM.	23d. LOCATION (City, town, or county) LEMAY COUNTY MO.		
24. FUNERAL DIRECTOR McClain Funeral		ADDRESS 4351 WASHINGTON	25. DATE RECD. BY LOCAL REG. SEP 28 57	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

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 *Leroy Pannister*

Licensed Embalmer No. 45

P. O. Address 4251 26th

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.