

Health,
Welfare
Public
Service

300
1-56

All
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33928
STATE FILE NUMBER
318 Primary Registration District No. 1003 Registrar's No. 8345

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS 412 S. Ewing	
3. NAME OF DECEASED (Type or print) James Nesbitt		4. DATE OF DEATH 8 29 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 Aug 22, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTH PLACE (City and state or country) Tenn	
13. FATHER'S NAME Dave Nesbitt		14. MOTHER'S MAIDEN NAME Myra Woodson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Cleo Hudson		Address 412 So Ewing	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) 332x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) Arteriosclerosis, Generalized			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 8-25-57 to 8-29-57 and last saw her him alive on 8-29-57 Death occurred at 5:20 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Sidney Fraser, M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 8-30-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept 6/57	
23c. NAME OF CEMETERY OR CREMATORY Father Dickson		23d. LOCATION (City, town, or county) St. Louis MO	
24. FUNERAL DIRECTOR J. A. Green 4214 Adams		25. DATE RECD. BY LOCAL REG. SEP 6 '57	
		26. REGISTRAR'S SIGNATURE Carl Smith MO	

(Licensed Embalmer's Statement on Reverse Side)

m 823

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 *not Embalmed*
F. A. Green

Licensed Embalmer No.....

P. O. Address *4214 Dal*

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.