

Health,  
& Welfare  
Public  
Service

S. 300  
v. 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37911

STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's **8325**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in lb <b>25yrs</b>		d. STREET ADDRESS <b>4204 Evans</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>Mumford</b> Last <b>Mumford</b>				4. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 3-16, 1897</b>	
9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Resturant Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Texas</b>	
13. FATHER'S NAME <b>Alfred Mumford</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>350 10 8584</b>		17. INFORMANT Address <b>Fannie Mumford 4204a E. Evans</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>443x</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Hemorrhage due to Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
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 <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>		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 <b>9-29-57</b> to <b>10-5-57</b> and last saw <sup>her</sup> <del>him</del> alive on <b>10-5-57</b> Death occurred at <b>6:45A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Sidney Trassler, M.D.</b>				22b. ADDRESS <b>2601 N. Whittier Street</b>		22c. DATE SIGNED <b>10-7-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10/10/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Charles J. Gates 4107 Finney</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 7 57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith</b>	

(Licensed Embalmer's Statement on Reverse Side)

3107

3107

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 *Gupton Swann* Licensed Embalmer No. 458

P. O. Address 4107 Finney

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.