

pt. Health,
c., & Welfare
S. Public
Health Service

XC-20 038 287

SL-13495

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

45780
STATE FILE NUMBER
12168

Registration District No.

Primary Registration District No.

Registrar's No.

V. S. 300
Rev. 1-57

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, MISSOURI		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 35 915 N. GRAND AVE.		d. STREET ADDRESS (If outside, give location) 5173 ENRIGHT AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last SHERMAN EASTER		4. DATE OF DEATH Month Day Year 12/16/57	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) E. ST. LOUIS, ILLINOIS
13a. FATHER'S NAME EDWARD EASTER		13b. MOTHER'S MAIDEN NAME FANNIE YOUNGBLOOD	14. NAME OF HUSBAND OR WIFE KATIE EASTER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VAH, 915 N. GRANS AVE., ST. LOUIS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO (b) LAENNECS' CIRRHOSIS DUE TO (c) - - - - - 581.1 - - - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - - - - -			INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 1 1/2 YEARS
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE <input checked="" 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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 9/19/57 to 12/16/57 and last saw him alive on 12/16/57 Death occurred at 11:20 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) Wesphaelinger		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 12/16/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-23-57	
23c. NAME OF CEMETERY OR CREMATORY WESTPHELINGER M.D. Washington Park, Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR Metropolitan Funeral System, Inc. 5010 Enright Ave.		25. DATE RECD. BY LOCAL REG. DEC 18 57	
26. REGISTRAR'S SIGNATURE Carl Smith MO mfb			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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

John K. Cunningham

Licensed Embalmer No. *4476*

P. O. Address *2405 Omnicus*

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.