

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007890
State File No.

1449
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) Homen G. Phillip Hos.		e. STREET ADDRESS (If rural, give location) 2112 330 Cass Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Vernon b. (Middle) Swope c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 2 6 58	
5. SEX M	6. COLOR OR RACE Cal	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) -	8. DATE OF BIRTH 4-8-1950
9. AGE (In years last birthday) 7		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School girl	11. BIRTHPLACE (City and State or Foreign Country) Brintwood Mo
13a. FATHER'S NAME Robert Swope		13b. MOTHER'S MAIDEN NAME Lecann Allen	
14. NAME OF HUSBAND OR WIFE -		12. CITIZEN OF WHAT COUNTRY? U.S.A	
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. none	
17. INFORMANT'S SIGNATURE OR NAME Lecann Swope		ADDRESS 2330 Cass Ave 303	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Influenza DUE TO (c) Virus Infection	
INTERVAL BETWEEN ONSET AND DEATH 30 days		30 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 480x	
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 1-19 , 19 58 , to Feb 2 , 19 58 , that I last saw the deceased alive on 2/2 , 19 58 , and that death occurred at 12 m., from the causes and on the date stated above.			
23a. SIGNATURE D. J. Moore M.D.		23b. ADDRESS 2330 Cass Ave	
23c. DATE SIGNED 2/6/58			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 2-11-58	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) County Mo	
DATE REC'D BY LOCAL REG. FEB 7 '58		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Gushowe		ADDRESS 2930 Dickson, St.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 U. Panniotte*

Licensed Embalmer No. *452*

P. O. Address *4251 Washu*

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.