

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007962
STATE FILE NUMBER

FILED FEB 28 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1580

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		d. STREET ADDRESS (If outside, give location) <u>4479 Clarence</u>	
Length of stay in lb <u>2 1/2 Weeks</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wini Fred</u> Middle <u>White</u> Last <u>White</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 29, 1871</u>
9. AGE (in years last birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>	11. BIRTHPLACE (City and state or country) <u>Brighton, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John W. White</u>	
13b. MOTHER'S MAIDEN NAME <u>Olivia Job</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT Address <u>Mrs. William Eckle - 4479 Clarence Avenue</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HEMORRHAGE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>331X</u>	
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 <u>undet.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <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 <u>Brighton, Illinois</u>		20g. COUNTY <u>Brighton, Illinois</u>	
20h. STATE <u>Illinois</u>		21. I attended the deceased from <u>1-22-58</u> to <u>2-9-58</u> and last saw her alive on <u>2-9-58</u> Death occurred at <u>4:27</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Paul Larson</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>2601 Whittier Street</u>	
22c. DATE SIGNED <u>2-10-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>Feb. 12, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brighton City Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Brighton, Illinois</u>		23e. STATE <u>Illinois</u>	
24. FUNERAL DIRECTOR <u>Math Hermann & Son, Inc. 2161 E. Fair</u>		25. DATE RECD. BY LOCAL REG. <u>FFR 11 '58</u>	
26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>			

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 *Allen W. Halz*
Student Embalmer No. *3737*

P. O. Address *St. Louis Mo*

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.