

FILED AUG 28 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8041

S. 300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 27 Homer G. Phillips Hosp. 0		Length of stay in lb	d. STREET ADDRESS 2129 5001 a. Enright Ave		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Darryl Wayne Custard			4. DATE OF DEATH Month Day Year 8 16 1958		
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1957	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days 9 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Louis, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME John Henry Atkins, Jr		13b. MOTHER'S MAIDEN NAME Delores Poiner		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Idella Emory 5149 Lexington Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spleen Congestion DUE TO (b) Lymphadenopathy DUE TO (c) 782.7 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
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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 650 A on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE James M Kelly Deputy		22b. ADDRESS 1300 Clark St		22c. DATE SIGNED 8-18-58	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/20/58		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
23d. LOCATION (City, town, or county) (State) St. Louis County Missouri					
24. FUNERAL DIRECTOR Pettis Mortuary 4181 Washington Ave.		25. DATE RECD. BY LOCAL REG. AUG 19 1958		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.	

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 *Edward G. Flynn*

Licensed Embalmer No. *4444*

P. O. Address *W. Harris*

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.