

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003632

STATE FILE NUMBER

FILED FEB 4 1959

Registration District No. .... Primary Registration District No. .... Registrar's No. **731**

1. PLACE OF DEATH a. COUNTY			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) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. HOMER G. PHILPS</b>		Length of stay in lb	d. STREET ADDRESS <b>4616 Lexington Ave.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>HENRY WILSON WHITE</b> <i>First Middle Last</i>			4. DATE OF DEATH <b>January 19 1959</b> <i>Month Day Year</i>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-6-1883</b>	9. AGE (In years last birthday) <b>76</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>WEST POINT, MISS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHNSON WHITE</b>			14. MOTHER'S MAIDEN NAME <b>MARGEY CANNON</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>JOHNSON WHITE</b> Address <b>4616 Lexington</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 Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____
					DUE TO (c) <b>443x</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					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.) <b>ITEM 4, 23b CORRECTED</b> <b>BY AFFIDAVIT OF Funeral Director</b> <b>2-9-59</b>		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
21. I attended the deceased from <b>1-7-59</b> , to <b>1-19-59</b> and last saw <sup>him</sup> alive on <b>1-16-59</b> Death occurred at <b>3:15 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>A. B. Smith, M.D.</b> (Degree or title)			22b. ADDRESS <b>11 N. Jefferson St Louis</b>		22c. DATE SIGNED <b>1-31-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>59</b> <b>1-23-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County MO.</b>	
24. FUNERAL DIRECTOR <b>SWAN-McGEE</b> UND. <b>1619 UNION</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 22 59</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

Use only black ink or ribbon typewrite if possible.  
 Ceremonial in Part I must be casually related.

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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.....

Licensed Embalmer No. *40*

P. O. Address *30 E*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
(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.