

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019761  
STATE FILE NUMBER  
2 4566

FILED MAY 22 1959 Registration District No. Primary Registration District No. Registrar's No.

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|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>St. Louis Missouri</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br><b>St. Louis</b>                 |  | c. CITY OR TOWN<br><b>St. Louis</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>D.O. A. Homer GPHI</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>4536 Garfield</b>   |  |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Infant Bill Earl White</b> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>May 8th 1959</b> |  |  |
|---|--|--|---|--|--|

|                       |                                |   |  |                                 |                                |                                |
|-----------------------|--------------------------------|---|--|---------------------------------|--------------------------------|--------------------------------|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>Col</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 1, 1959</b> | 9. AGE (In years last birthday) | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
|-----------------------|--------------------------------|---|--|---------------------------------|--------------------------------|--------------------------------|

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|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mill</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mill</b> | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Missouri</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b> |
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|--|--|---|
| 13a. FATHER'S NAME<br><b>Wille White</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Eddie Lee Hood</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Mr Willée White</b> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>No</b> | 17. INFORMANT<br><b>Mr Willie White</b> | Address<br><b>4536 Garfield Ave</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) <b>492X</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?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|--|
| 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.) |
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|                                       |   |  |                              |        |       |
|---------------------------------------|---|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY<br>Hour 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 |
|---------------------------------------|---|--|------------------------------|--------|-------|

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| 21. I attended the deceased from _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><b>Paul J. Simon</b> (Degree of <b>Coroner</b> ) | 22b. ADDRESS<br><b>1300 Clark</b> | 22c. DATE SIGNED<br><b>5/9/59</b> |
|--|-----------------------------------|-----------------------------------|

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>5/11/59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County Missouri</b> |
|---|-----------------------------|--|---|

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|--|----------------------------------|---|--|
| 24. FUNERAL DIRECTOR<br><b>Herman J. Smith</b> | ADDRESS<br><b>4247/w Labadie</b> | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 11 '59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b> |
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *H. C. Claude Good*

Licensed Embalmer No... *3489*

P. O. Address... ~~*4575 1st St*~~

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.

*4500 Newbr*  
*Jer*