

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022739

FILED JUL 13 1959

STATE FILE NUMBER
2 6256

Registration District No. _____ Primary Registration District No. _____

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 5039 Vernon	
3. NAME OF DECEASED (Type or print) First Cassandra Middle Ann Last Buckner		4. DATE OF DEATH Month 6 Day 27 Year 59	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Saint Louis, Missouri
13a. FATHER'S NAME Arthur Buckner		13b. MOTHER'S MAIDEN NAME Geneva Lockhart	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Homer Phillips Address 2601 N. Whittier
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth, Neonatal death			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			762.5
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Partial atelectasis congestion			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 6-26-59 to 6-27-59 and last saw her alive on 6-27-59 Death occurred at 2:30 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Park White, M.D. (Degree or title)		22b. ADDRESS 2601 N. Whittier	22c. DATE SIGNED 6-20-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-31-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Rawland Akel 4104 N. Grand ADDRESS		25. DATE RECD. BY LOCAL REG. JUL 2 '59	26. REGISTRAR'S SIGNATURE W. Earl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally 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.....

P. O. Address.....

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.