

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 18 1960

=60-017355

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's 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		Length of stay in 1b 1 yr		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5019 Page		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Tinnie Middle Soloman Last				4. DATE OF DEATH Month 4 Day 2 Year 60				
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-30-30	9. AGE (last birthday) 30	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Glen Allen, Miss	12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME Will Williams			13b. MOTHER'S MAIDEN NAME Easter			14. NAME OF HUSBAND OR WIFE Levi Solomon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No		17. INFORMANT Address Levi Solomon 5019 Page Blvd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to Abruptio Placenta							INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		6706.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Sickle Cell Anemia						PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 10:30 Month, Day, Year 3-30-60 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 Glen Allen		20g. COUNTY STATE		
20d. INJURY OCCURRED WHILE AT WORK <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 Glen Allen		20g. COUNTY STATE		
21. I attended the deceased from 3-30-60 to 4-2-60 and last saw her ^{her} _{10:30} alive on 4-2-60 Death occurred at 10:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Will Smalley</i> (Deceased or title)				22b. ADDRESS 2601 N. Whittier St.		22c. DATE SIGNED 4-4-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Rempval		23b. DATE 4-8-60	23c. NAME OF CEMETERY OR CREMATORY Glen Allen		23d. LOCATION (City, town, or county) (State) Miss			
24. FUNERAL DIRECTOR JAS H. RANDLE & SON 3133 Bell Ave			25. DATE RECD. BY LOCAL REG. APR 5 1960		26. REGISTRAR'S SIGNATURE <i>Local Registrar, H. D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MVB

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Ester H. Harris*

Licensed Embalmer No. 4458

P. O. Address 4181 Wash

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.