

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3862a Page	

3. NAME OF DECEASED (Type or print) First Nathaniel Middle Phelps Last			4. DATE OF DEATH Month 12 Day 2 Year 60		
5. SEX Male	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 10-23-1911	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months 1 Days 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Tennessee	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Jim Phelps		13b. MOTHER'S MAIDEN NAME Ella ?		14. NAME OF HUSBAND OR WIFE Annie Phelps	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW2	16. SOCIAL SECURITY NO. 493-69-0717	17. INFORMANT Annie Phelps	Address 3862 Page Avenue
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with Metastasis to Pleura, Ribs, Liver, Spleen, Kidneys, Axillary and Mediastinal Lymph Nodes		Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) 162.1	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour p.m. Month, Day, Year	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 COUNTY STATE
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21. I attended the deceased from 8-27-60 to 12-2-60 and last saw ^{per} him alive on 12-2-60	
Death occurred at 1:53 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE D. Whittle M.D.	(Degree or title)	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 12-3-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-7-60	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Plks. Missouri
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24. FUNERAL DIRECTOR Ellis Funeral Home, 2820 Stoddard Street	25. DATE RECD. BY LOCAL REG. DEC 5 1960	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Hutton E. Cull

Licensed Embalmer No. 419
P. O. Address Stau

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.