

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-031132

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7965** STATE FILE NUMBER

FILED AUG 31 1961

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) 412 N. 15th
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Frank Middle Last Southern	4. DATE OF DEATH Month 8 Day 24 Year 61
---------------------------------------------------------------------------------------	-----------------------------------------------------------------

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 May	9. AGE (last birthday) 2nd 1897	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
--------------------	-------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------	-------------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of year, even if retired) Teacher	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mariana Ark.	12. CITIZEN OF WHAT COUNTRY U.S.A.
-------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME Albert Southern	13b. MOTHER'S MAIDEN NAME Mollie Ricks	14. NAME OF HUSBAND OR WIFE Vergie Lee Southern
----------------------------------------------	--------------------------------------------------	-----------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service)	17. INFORMANT Address Verhie Lee Southern 1420 N 15th St.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Adenocarcinoma of Prostate		Undet.
DUE TO (c) 177x		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Congestive Heart Failure due to Arteriosclerotic/Heart Disease		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
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

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.)
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	------------------------------	--------	-------

21. I attended the deceased from 7-23-61 to 8-24-61 and last saw him alive on 8-24-61
Death occurred at 5:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) Sydney A. Fraser M. D.	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 8-24-61
---------------------------------------------------------------------	---------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE 8-29-61	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem	23d. LOCATION (City, town, or county) (State) Berkley Mo
----------------------------------------------------------------	-----------------------------	------------------------------------------------------------------	--------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS A. L. Beal Und Co 4303 Delmar	25. DATE RECD. BY LOCAL REG. AUG 26 1961	REGISTRAR'S SIGNATURE Roald Smith. M.D.
-------------------------------------------------------------------------	----------------------------------------------------	---------------------------------------------------

DATE AMENDED

STATEMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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

Arthur L. Herliand

Licensed Embalmer No. 4221

P. O. Address 3100 Easton a

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.