

V. S. No. 2
100M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15093**

FILED MAY 31 1946
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3722**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Louis City Hospital-Max Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME CHARLES PHILLIPS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 29th, 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 1 1/2 min.

9. Birthplace St. Louis City Hospital
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER

12. Name Charles Phillips

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Elsie Unknown

15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant St. Louis City Hospital

(b) Address _____

17. (a) ~~(Burial/cremation, _____)~~ (b) Date thereof 4-25-46
(Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director W. G. White

(b) Address City Hospital No. 1

19. (a) APR 25 1946 (Date received local registrar) J. F. Brudeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 918 Morrison Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29th
year 1946 hour 6:07 minute P M.

21. I hereby certify that I attended the deceased from 1/29/46
to 1/29/46, 19____, to _____, 19____

that I last saw him alive on 1/29/46, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Ineluctation

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature M. J. Carson 1/30/46 (M.D. or other)
Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

13993

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.....
....., Registered Apprentice No.....
working under my personal supervision.

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 this body is not embalmed, fact should be so stated above.