S. No. 2.
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 10 1948

Registration District No. 917

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43883

Primary Registration District No. 6076

Registrar's No. 275-6

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 85 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 706 No. Kingshighway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WHITEHEAD, EUGENE
3. (b) If veteran, name war
3. (c) Social Security No. 498-07-7260
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rose Brandel Whitehead
6. (c) Age of husband or wife if alive years
7. Birth date of deceased September (Month) 26 (Day) 1911 (Year)

8. AGE:

Years	Months	Days	If less than one day
36	3	5	hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Salesman
11. Industry or business
FATHER
12. Name Ernest Whitehead
13. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Elizabeth Holloman
15. Birthplace (City, town, or county) Illinois (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 1-2-47 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemetery
18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Avenue
19. (a) 1-1-48 (Date received local registrar) (b) Cecil A. J. Sharp MD MSA (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 31
year 1947 hour 6 minute 45 A. M.
21. I hereby certify that I attended the deceased from 10-7-47, 19, to 12-31-47, 19;
that I last saw him alive on 12-31-47, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	9 mo. (?)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Diabetes	
Major findings: Of operations	
Of autopsy Same	

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. or other)
Address Robt. Koch Hospital Date signed 12/31/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 D W Cooper

Licensed Embalmer No. 13830

P. O. Address 2301 Lafayette

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.