

FILED JAN 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2426**
Registrar's No. **469**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Coronet to Homer Phelps		d. STREET ADDRESS (If rural, give location) 2620 Thomas St.	

3. NAME OF DECEASED (Type or Print) CHARLIE ATKINSON			4. DATE OF DEATH (Month) (Day) (Year) Jan. 13 1949		
5. SEX Male	6. COLOR OR RACE Cal	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 3-13-1870		9. AGE (In years last birthday) 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) atlanta Ga.		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Charles Atkins on	13b. MOTHER'S MAIDEN NAME mat known	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Andrey Harris	ADDRESS 2620 Thomas
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Thrombosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		9/4/201	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to **1-12**, 19**49**, that I last saw the deceased alive on _____, 19____, and that death occurred at **4:40 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE Joseph M. Quinn	(Degree or title) County 3	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 1/14/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-14-49	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) County 3
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DATE REC'D BY LOCAL JAN 17 1949	REGISTRAR'S SIGNATURE J. B. Pasater	25. FUNERAL DIRECTOR'S SIGNATURE AP Richardson	ADDRESS 2620 Thomas
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed.....

Signed.....

Student Embalmer

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.