

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2610

BIRTH NO. 49-004065 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 895

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY <i>St. Louis</i> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | c. LENGTH OF STAY (In this place) 4 hr. 25m. | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips <i>D</i> | | d. STREET ADDRESS (If rural, give location) 716 1/2 S. 4th <i>J</i> | |

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|---|------------------------|---|---|--|-----------------------------------|
| 3. NAME OF DECEASED (Type or Print) <i>Infant Doby</i> | | | 4. DATE OF DEATH (Month) (Day) (Year) 1 23 49 | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>1</i> | 8. DATE OF BIRTH 1-23-49 | | 9. AGE (In years last birthday) 4 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Missouri <i>J</i> | | 12. CITIZEN OF WHAT COUNTRY? |

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| 13a. FATHER'S NAME John Henry Doby | 13b. MOTHER'S MAIDEN NAME Leder Mae Brockin | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Ester M. Shvard, 2601 N. Whittier</i> | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity | DUE TO (b) <i>159</i> | | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | DUE TO (c) <i>plex</i> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Intracranial Hemorrhage | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) | 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 1-23-1949, to 1-23-1949, that I last saw the deceased alive on 1-23-1949, and that death occurred at 11:25a., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or Title) <i>W. F. Sinkler M.D.</i> | 23b. ADDRESS 2601 N. Whittier | 23c. DATE SIGNED 1/27/49 |
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|---|-----------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE JAN-31-1949 | 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board | 24d. LOCATION (City, town, or county) (State) |
|---|-----------------------|---|---|

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| DATE REC'D BY LOCAL REG. JAN 31 1949 | REGISTRAR'S SIGNATURE <i>J. B. Laster</i> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service 4104 Manchester Ave. |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.