

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
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, 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. STREET ADDRESS (If rural, give location) 2610 Cole St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				d. STREET ADDRESS (If rural, give location) 2610 Cole St.			
3. NAME OF DECEASED (Type or Print) George		a. (First)		b. (Middle)		c. (Last) Givens	
4. DATE OF DEATH (Month) (Day) (Year) Jan. 14 1949		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH Sept 14, 1880		9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		11. BIRTHPLACE (State or foreign country) St. Louis, Mo	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME John Givens		13b. MOTHER'S MAIDEN NAME Mary Curtis		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Iona Coker 4520 St. Ferdinand			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart Disease with, Decompensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undet. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension				INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)	
21d. TIME OF INJURY		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 Dec. 31, 1948, to Jan. 14, 1949, that I last saw the deceased alive on Jan. 14, 1949, and that death occurred at m., from the causes and on the date stated above.							
23a. SIGNATURE Oscar L. David (Degree or title) M. D.				23b. ADDRESS 2601 N. Whittier St.		23c. DATE SIGNED 1-17-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/18/49		24c. NAME OF CEMETERY OR CREMATORY St. Peter's		24d. LOCATION (City, town, or county) (State) St. Louis, Mo	
DATE REC'D BY LOCAL REG. JAN 17 1949		REGISTRAR'S SIGNATURE J. B. Parmer		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.W. Roberts 1416 N. Taylor Ave.			

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. 290

working under my personal supervision.

Student James Carter
Student Embalmer

Signed Hutton E. Culkin

Licensed Embalmer No. 498

P. O. Address St. Louis 13

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.