

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14159

BIRTH NO. 49-125649 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3866

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. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If rural, give location) 4806a Washington	
3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle) c. (Last) Shannon		4. DATE OF DEATH (Month) (Day) (Year) 3 31 49	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 3-31-49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Mtn. 1 40
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Grace Shannon	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)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lester M. Shevard, R.R. 2601 N. Whittier
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) Prematurity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 159	
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? 776X	
22. I hereby certify that I attended the deceased from 3-31-1949, to 3-31-1949, that I last saw the deceased alive on 3-31-1949, and that death occurred at 10:10 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. H. Dinkels, M.D.		23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 4-6-49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE APR 30 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. APR 30 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service 4104 Manchester Ave.	

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

2

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.