

No. 300
10.48

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27957

State File No. 7430

318

1003

Registrar's No.

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY b 000	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (In this place) 26	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 1 1/4	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 12- 4544 Newberry Terrace 16	

3. NAME OF DECEASED (Type or Print) a. (First) Lee	b. (Middle)	c. (Last) Daniels	4. DATE OF DEATH (Month) (Day) (Year) August 24 1949
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5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8/27/1865	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 11 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY /Self	11. BIRTHPLACE (State or foreign country) Lake Village, Ark.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Daniels	13b. MOTHER'S MAIDEN NAME Martha Bullet	14. NAME OF HUSBAND OR WIFE Mary
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ernestine Bryd	ADDRESS 4544 Newberry
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Disease		Undet.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Lobar Pneumonia			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) 9 (STATE)
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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? 44 2X
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22. I hereby certify that I attended the deceased from 8-19, 19 49, to 8-24, 1949, that I last saw the deceased alive on 8-24, 19 49, and that death occurred at 1:30p m., from the causes and on the date stated above.

23a. SIGNATURE James J. Helbeck M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 8-25-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/30/49	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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DATE REC'D BY LOCAL REG. AUG 28 1949	REGISTRAR'S SIGNATURE J B Foster	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates	ADDRESS 4107 Finney
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

paid

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.

Student
Student Embalmer

Signed _____

John H. Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Juney Ave

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.