

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34997

State File No. _____

BIRTH NO. 67213-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9347

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>HOMER G. PHILLIPS HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>(1) 8309 Polk</u>	

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
		<u>Infant</u>	<u>Carlyle</u>	<u>10</u> <u>5</u> <u>49</u>

5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>10-2-49</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Min.
					<u>2</u>	<u>15</u>	<u>10</u>
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) <u>0</u>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME <u>Johnnie Carlyle</u>	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 <u>E. Howard</u>	ADDRESS <u>R.R. 2601 N. Whittier</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

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) <u>1391</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>776X</u>
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22. I hereby certify that I attended the deceased from 10-2-, 1949, to 10-5-, 1949, that I last saw the deceased alive on 10-5-, 1949, and that death occurred at 2:35 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>M. D.</u>	23b. ADDRESS <u>2601 N. Whittier</u>	23c. DATE SIGNED <u>10-11-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>OCT 31 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <u>OCT 31 1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 19, Mo.</u>
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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.

Student
Student Embalmer

Signed.....

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.