

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35698

State File No. 9121

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		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) 4 days		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital				d. STREET ADDRESS (If rural, give location) 4873 Page			
3. NAME OF DECEASED (Type or Print)		a. (First) Sylvanus		b. (Middle) M.		c. (Last) Whitaker	
4. DATE OF DEATH (Month) (Day) (Year) Oct. 22, 1949		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	
8. DATE OF BIRTH April 7, 1886		9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Abraham Whitaker		13b. MOTHER'S MAIDEN NAME Martha Gerry	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Susan D. Whitaker, 4873 Page	
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, asthenia, 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				INTERVAL BETWEEN ONSET AND DEATH Unknown			
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 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) 930			
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? 4200			
22. I hereby certify that I attended the deceased from 10-19, 1949 to 10-22, 1949 , that I last saw the deceased alive on 10-22, 1949 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE F. Mangano (Degree or title) Ind. U.				23b. ADDRESS 2801 N. Taylor Ave		23c. DATE SIGNED 10-24-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/25/49		24c. NAME OF CEMETERY OR CREMATORY Old Odd Fellows Cem.		24d. LOCATION (City, town, or county) (State) Shelbina, Missouri	
DATE REC'D BY LOCAL REG. OCT 24 1949		REGISTRAR'S SIGNATURE J. B. Sarter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PROVOST UND. CO., 3710 N. Grand Bl.			

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Albert Mayfield

Signed _____
Student Embalmer

Licensed Embalmer No. _____

3077

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.