

FILED FEB 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003 State File No. 6491
REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1074 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
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 Hospital		d. STREET ADDRESS (If rural, give location) 25 - 1117, North 14th Street	
3. NAME OF DECEASED (Type or Print) Tom Mack		4. DATE OF DEATH (Month) (Day) (Year) Jan. 30, 1950	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 27th 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY McClain Poltry Co	9. AGE (In years last birthday) Months Days 53 2 3
11. BIRTHPLACE (State or foreign country) Memphis Shelby Co. Tenn		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME William Mack		13b. MOTHER'S MAIDEN NAME Kitty Carrol	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 None		16. SOCIAL SECURITY NO. 491-14-7725	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Miller 1413, Carr Street
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis 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. Pyelonephritis and Uremia	
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) 232X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) 5:00		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-28, 1950, to 1-30, 1950, that I last saw the deceased alive on 1-30, 1950, and that death occurred at 1:50p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) James J. Hedrick D. O		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 2-1-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-3-50	
24c. NAME OF CEMETERY OR CREMATORY Green Wood Cemetery		24d. LOCATION (City, town, or county) (State) ST. Louis, Missouri	
25. FUNERAL DIRECTOR'S SIGNATURE J. B. Lasater		ADDRESS 2829, Washington Blvd	
DATE REC'D BY LOCAL REG. FEB 3 1950		REGISTRAR'S SIGNATURE John H. Houston	

(Licensed Embalmer's Statement on Reverse Side)

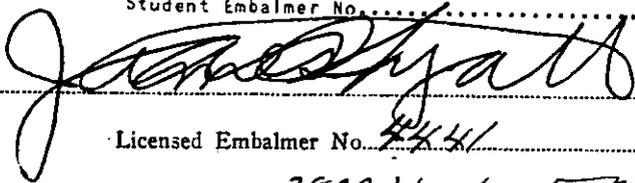
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.

Signed.....


Signed.....
Student Embalmer

Licensed Embalmer No. 4441

P. O. Address 2828 Washington Blvd
St. Louis 3, Mo

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.