

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 6763
1324
Registrar's No.

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

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

1. PLACE OF DEATH a. COUNTY MO b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY 2254 c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS d. STREET ADDRESS (If rural, give location) 23 1738 O'FALLON ST.	
3. NAME OF DECEASED a. (First) LUCINDA b. (Middle) RHODES c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) 2-4-50	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 15 1896
9. AGE (In years last birthday) 53 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Yazoo, Miss
11. BIRTHPLACE (State or foreign country) Yazoo, Miss		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE George Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Johnnie Rhodes, 1327 Carr St	
MEDICAL CERTIFICATION			
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Antecedent Causes DUE TO (b) Cerebral Hemorrhage Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 checked="" 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) (STATE) 331X		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?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:30 A.M., from the causes and on the date stated above.			
22a. SIGNATURE (Degree or title) Patrick E. Taylor, Coroner		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 2-6-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-14-50	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO	
DATE REC'D BY LOCAL REG. FEB 10 1950		REGISTRAR'S SIGNATURE J. B. Casater	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Robinson & Sons, 1720 O'Fallon St			

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.....

Leroy W. Pannister

Licensed Embalmer No. *4523*

P. O. Address *3880 Easton 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.