

FILED MAR 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10954

State File No. 2043

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 10-10-49	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Granite City 8120	
		d. STREET ADDRESS (If rural, give location) 8	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) William		b. (Middle) T	
		c. (Last) Phillips	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH 9-21-1943	
9. AGE (In years last birthday) 6-1-17		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY child	
11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME William Phillips		13b. MOTHER'S MAIDEN NAME Dorothy Marich	
14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME William Phillips		ADDRESS Granite City, Mo.	
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) <u>Acute Myocardial Failure</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Post-Polio respiratory case quadriplegia</u> DUE TO (c) <u>Pulmonary Edema</u> 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) 081X			
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?			
22. I hereby certify that I attended the deceased from 10-10-1949, to 3-1-1950, that I last saw the deceased alive on 3-1-1950, and that death occurred at 3-1-1950, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) M. W. D.		23b. ADDRESS 3520 Chippewa	
23c. DATE SIGNED 3/1/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removed		24b. DATE 3-2-50	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Granite City, Mo.	
DATE REC'D BY LOCAL REG. MAR 3 1950		REGISTRAR'S SIGNATURE J. B. Lassiter	
25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Services Inc.		4104 Manchester Ave. St. Louis 10, Mo.	

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

2043

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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 *Ronald A. Yalmar* _____

Licensed Embalmer No. *3917* _____

P. O. Address *St Louis, 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.