

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **18762**
Registrar's No. **4776**FILED JUN 9 1950
BIRTH NO. **31710 50** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 2hrs40mins	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			d. STREET ADDRESS (If rural, give location) 21 3331 Laclede 0		
3. NAME OF DECEASED (Type or Print) a. (First) Infant		b. (Middle)	c. (Last) Wells	4. DATE OF DEATH (Month) (Day) (Year) 5-21-50	
5. SEX Fem. 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 5-21-50	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months
IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.	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) 0
12. CITIZEN OF WHAT COUNTRY?	13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME Estella Wells	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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. M. Seard RR-2601 N. Whittier			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	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) 756X		21d. (STATE)	
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 5-21- , 19 50 , to 5-21- , 19 50 , that I last saw the deceased alive on 5-21- , 19 50 , and that death occurred at 8:05 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE W. S. Seubler		(Degree or title) 0	23b. ADDRESS M. D. 2601 N. Whittier		23c. DATE SIGNED 5-24-50
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. MAY 31 1950	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. MAY 31 1950	REGISTRAR'S SIGNATURE J. B. Pasater	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.		ADDRESS Manchester Ave. St. Louis 10, Mo.	

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.....

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.