

FILED JUN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21470
5178

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).	
b. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS		a. STATE MISSOURI	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION HOMER G. PHILLIPS HOSP.		d. STREET ADDRESS (If rural, give location) 1802 BELLEGLADE	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) SANKER			b. (Middle) DICKERSON		
c. (Last)			5. SEX M		
6. COLOR OR RACE COL			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		
8. DATE OF BIRTH 2-28-87			9. AGE (In years last birthday) 63		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL			10b. KIND OF BUSINESS OR INDUSTRY ✓		
11. BIRTHPLACE (State or foreign country) CHRISTIAN CO. KY.			12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		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 Mary Mitchell	
				ADDRESS 1802 Belle Glade	

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)		Internal Ecchymosis					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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) (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? 4117 X	

22. I hereby certify that I attended the deceased from 4-20-1950, to 6-27-1950, that I last saw the deceased alive on 7-1950, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE J.W. Wilkerson M.D.		23b. ADDRESS 4141 Page		23c. DATE SIGNED 6-12-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 6-14-50		24c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM.	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO		25. FUNERAL DIRECTOR'S SIGNATURE A.F. Walton		ADDRESS 2707 STODDARD	
DATE REC'D BY LOCAL REG. JUN 13 1950		REGISTRAR'S SIGNATURE A.B. Pasater			

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

Joseph J. ...

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 *Arthur L. Kelliard*

Licensed Embalmer No. *4221*

P. O. Address *4049 St Judens*

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.