

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35060

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8558**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillis		d. STREET ADDRESS (If rural, give location) 4648 Kennerly ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Vinnie b. (Middle) c. (Last) Lyles			4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1950		
5. SEX 3 female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 16, 1886	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 7 Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Monticello, Ark	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME Bob Burks	13b. MOTHER'S MAIDEN NAME Nancy Harris	14. NAME OF HUSBAND OR WIFE James Lyles
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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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Lyles 4648 Kennerly ave.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension 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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 334X
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22. I hereby certify that I attended the deceased from **Jan 1**, 19**50**, to **Oct 8**, 19**50**, that I last saw the deceased alive on _____, 19____, and that death occurred at **1:0** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. A. Young M.D.	23b. ADDRESS 2337 Market	23c. DATE SIGNED 10-10-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Oct. 14, 1950	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis, county, Mo.
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DATE REC'D BY LOCAL REG. OCT 10 1950	REGISTRAR'S SIGNATURE J. B. Kester	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Dement & Son 2629-31 Cole Street
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2 cap

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 H. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.