

FILED APR 9 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003  
10089  
State File No. 2992

BIRTH NO. 19021-51 REG. DIST. NO. 210 PRIMARY REG. DIST. NO. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>4772 St. Louis Avenue</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Infant</b> b. (Middle) c. (Last) <b>Frazier</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>3 30 51</b>	
5. SEX <b>Male</b> <input checked="" type="checkbox"/>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>1)</b>	8. DATE OF BIRTH <b>3-29-51</b>
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <b>Breard Frazier</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Goodwin</b>	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 <b>Arthur M. Sherard, 2601 N. Whittier St.</b>

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <b>Prematurity</b>  ANTECEDENT CAUSES DUE TO (b) <b>Unknown</b> DUE TO (c) <b>Unknown</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>776X</b>

22. I hereby certify that I attended the deceased from **3-29-** 19 **51**, to **3-30-** 19 **51**, that I last saw the deceased alive on **3-30-** 19 **51**, and that death occurred at **3:40 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>John L. Lewis</b> (Degree or title) <b>M. D.</b>		23b. ADDRESS <b>2601 N. Whittier</b>	23c. DATE SIGNED <b>3-30-51</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>3-31-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis County Mo</b>
DATE REC'D BY LOCAL REG. <b>MAR 30 1951</b>	REGISTRAR'S SIGNATURE <b>J B Foster</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>AB Richards 2625 Glasgow</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

**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 *AD Prohaska*.....

Licensed Embalmer No. *2988*.....

P. O. Address *City*.....

**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.