

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18494

State File No. _____
Registrar's No. **4572**

BIRTH NO. 33294-51 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 town) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 2119 0 4215 Evans
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital					
3. NAME OF DECEASED (Type or Print) a. (First) LeeVirt b. (Middle) c. (Last) Quillar Jr.			4. DATE OF DEATH (Month) (Day) (Year) 5 4 51		
5. SEX 2 Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED 0	8. DATE OF BIRTH 5-4-51		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days IF UNDER 10 HRS: Hours Min. 8 32
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 LeeVirt Quillar		13b. MOTHER'S MAIDEN NAME Margaret Hewitt		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 Ester M. Leonard, R.N.			
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) Prematurity 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. None				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None			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? 776X			
22. I hereby certify that I attended the deceased from 5-4-1951 , to 5-4-1951 , that I last saw the deceased alive on 5-4-1951 , and that death occurred at 3:00 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE W. H. [Signature]			23b. ADDRESS M. D. 2601 N. Whittier	23c. DATE SIGNED 5-10-51	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6 MAY 16 1951	24c. NAME OF CEMETERY OR CREMATORY Anatomical Bldg	24d. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. MAY 16 1951		REGISTRAR'S SIGNATURE J. B. [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	

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 _____

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.