

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39514

FILED DEC 8 - 1951

State File No. 10564
Registrar's No. 10564

BIRTH NO. 21157-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002

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) 23hrs 38mins		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
		d. STREET ADDRESS (If rural, give location) 4047 St. Ferdinand	

3. NAME OF DECEASED (Type or Print)	a. (First) Warren	b. (Middle) Stacey	c. (Last) Nick	4. DATE OF DEATH (Month) (Day) (Year) 11 19 51
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) C	8. DATE OF BIRTH 11-18-51	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min. 23 38
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) Missouri	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		
		13b. MOTHER'S MAIDEN NAME Mary Lee Nick		
		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 Arthur M. Sherrard		ADDRESS 2601 N. Whittier
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth			
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Probable Atelectasis			
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) (Min.)	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 11-18-19 51 to 11-19-19 51 that I last saw the deceased alive on 11-19-19 51, and that death occurred at 11:00 AM on the causes and on the date stated above.

23a. SIGNATURE W. S. Sherrard	(Degree or title) M. D. D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 11-21-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE NOV 28 1951 6	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. NOV 28 1951	REGISTRAR'S SIGNATURE Arthur M. Sherrard	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS 4104 Manchester Ave
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(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.....

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.