

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6622

State File No. 1605

FILED MAR 5 1952

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). 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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 321 S Garrison	

3. NAME OF DECEASED (Type or Print) Theodore	a. (First)	b. (Middle)	c. (Last) Melton	4. DATE OF DEATH (Month) (Day) (Year) Feb. 16 1952
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NO	8. DATE OF BIRTH Jan. 2 - 52	9. AGE (In years last birthday) (Specify) 1 MONTH 14 DAYS	10. CITIZENSHIP OF WHAT COUNTRY? U S A
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) St Louis MO	12. CITIZENSHIP OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Jessie Melton	13b. MOTHER'S MAIDEN NAME Powell	14. NAME OF HUSBAND OR WIFE None
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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. NO	17. INFORMANT'S SIGNATURE OR NAME Jessie Melton	ADDRESS 321 S Garrison
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Deformity of Brain		
	ANTECEDENT CAUSES DUE TO (b) Undetermined DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Inguinal Hernia; Club Foot			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 752.1
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22. I hereby certify that I attended the deceased from **2-14**, 19**52**, to **2-16**, 19**52**, that I last saw the deceased alive on **2-16**, 19**52**, and that death occurred at **6:20p m.**, from the causes and on the date stated above.

23a. SIGNATURE John H. Lewis	(Degree or title) M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 2-18-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Feb. 21. 52	24c. NAME OF CEMETERY OR CREMATORY Day Dale Cemetery	24d. LOCATION (City, town, or county) (State) St Louis CO
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DATE REC'D BY LOCAL REG. FEB 20 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Boyd Bros	ADDRESS 3706 Finney Ave
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26. (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 Henry C. Williams

Licensed Embalmer No. 4791

P. O. Address 1205 Walters

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.