

FILED JUL 22 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25534**
6716

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1004		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY 0				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2257			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) Unknown		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 25 1534 Franklin	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 25 1534 Franklin			
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) c. (Last) Anderson			4. DATE OF DEATH (Month) (Day) (Year) June 19 1952				
5. SEX Male 2		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 2		8. DATE OF BIRTH Feb. 5, 1887	
9. AGE (in years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) xxxx Laborer		11. BIRTHPLACE (City and State or Foreign Country) Not known 9		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) xxxx Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Not known 9		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME Not known		13b. MOTHER'S MAIDEN NAME Not known		14. NAME OF HUSBAND OR WIFE Not known			
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. Not known		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elizabeth Rhodes, 2601 N Whittier St.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Arteriosclerosis DUE TO (c) None 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 Undet.
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.)	
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? 331X			
22. I hereby certify that I attended the deceased from 6-15 , 19 52 , to 6-19 , 19 52 , that I last saw the deceased alive on 6-19 , 19 52 , and that death occurred at 2:10a m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) E. Brasko, M. D.				23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 6-20-52	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 7-31-52		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JUL 1 1952		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service 106 Manchester Ave.			

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

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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.