

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 8 - 1952

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State File No. 29614

Registrar's No. 8196

BIRTH NO. _____		REG. DIST. NO. _____		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 <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. Louis</u> <u>0</u>		c. LENGTH OF STAY (in this place) <u>36 Yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2727 2728, A. Eugenia</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Dolph</u>			b. (Middle) _____		c. (Last) <u>Ireland</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8 - 27 - 1952</u>
5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>12 - 26th, -1879</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>8</u>	IF UNDER 24 HRS. Days <u>1</u> Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Crawford / Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Dolph. Ireland</u>		13b. MOTHER'S MAIDEN NAME <u>Louise Phifer</u>		14. NAME OF HUSBAND OR WIFE <u>Ella Ireland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. A. Ireland 2728, Delmar. Blvd.</u>			
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) <u>Bronchu Pneumonia - Dislocation</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>4 Cervical Vertebrae & Intervertebral</u> DUE TO (c) <u>Thrombosis Spinal Veins</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>farm</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Forest Dale Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) <u>Aug 1 1952 6:00 am</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from horse. 845 x.</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Special Physician</u> Deputy (Degree or title)				23b. ADDRESS <u>1300 Clark</u>		23c. DATE SIGNED <u>8/27/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8/30/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakland Baptist Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Crawford Mississippi</u>	
DATE REC'D BY LOCAL REG. <u>AUG 29 1952</u>		REGISTRAR'S SIGNATURE <u>Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John Houston 2829, Washington Blvd.</u>			

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

Leroy W. Gannister

Licensed Embalmer No. 45-23

P. O. Address 3880 Easton Ave

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.