

FILED FEB 3 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3873**  
Registrar's No. **0726**

BIRTH NO. \_\_\_\_\_ 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 <b>Mo</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) <b>St Louis Mo</b>		c. LENGTH OF STAY (In this place) <b>3 hrs</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>St Louis</b>		2259
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homee G. Phillips</b>			d. STREET ADDRESS (If rural, give location) <b>25 1234 N 13th St</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Alfred</b> b. (Middle) <b>W</b> c. (Last) <b>Vaught</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>1 19 53</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Oct. 13, 1919</b>	9. AGE (In years last birthday) <b>33</b>	10. UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St Louis, Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <del>XXXXXXXXXXXX</del>		13b. MOTHER'S MAIDEN NAME <b>Rebecca Vaught</b>		14. NAME OF HUSBAND OR WIFE <b>Never Married</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Rebecca Vaught</b>		
				17. ADDRESS <b>1234 N 13th St</b>	

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			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b) <b>Acute Lymphatic</b>			
ANTECEDENT CAUSES		DUE TO (c) <b>Leukemia</b>			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>2040</b>			

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 **12 noon** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Carl Smith</b> (Print name or title)		23b. ADDRESS <b>1500 Clark</b>		23c. DATE SIGNED <b>1/20/53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bury</b>	24b. DATE <b>Jan. 23, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis County Mo</b>		
DATE REC'D BY LOCAL REG. <b>JAN 22 1953</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERARY DIRECTOR'S SIGNATURE ADDRESS <b>MO Boyd Funeral Home 3707 Finney</b>		

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

*Leahuel E. Anderson*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

*347  
St. Lawrence*

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.