

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15965**
4039

FILED MAY 14 1953

318

1003

Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. _____		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. LENGTH OF STAY (in this place) 4 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 4751 St. Louis			
3. NAME OF DECEASED (Type or Print) a. (First) Sterling		b. (Middle) _____		c. (Last) McFerrin		4. DATE OF DEATH (Month) (Day) (Year) April 16 1953	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 8, 1885	
9. AGE (in years last birthday) 68		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Wynne, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Captain McFerrin		13b. MOTHER'S MAIDEN NAME Annie Cross		14. NAME OF HUSBAND OR WIFE Marea McFerrin			
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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marea McFerrin, 4751 St. Louis Ave.			
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) Carcinoma of Rectum ANTECEDENT CAUSES DUE TO (b) Undetermined <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Malnutrition and Secondary Anemia				INTERVAL BETWEEN ONSET AND DEATH Undet. 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.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 15'X			
22. I hereby certify that I attended the deceased from 3-19 , 19 53 , to 4-16 , 19 53 , that I last saw the deceased alive on 4-16 , 19 53 , and that death occurred at 7:38a m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Thomas H. Brewer, D. O.				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 4-16-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4/21/1953		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. APR 18 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. J. Baker & Son Funeral Home 3201 N. Newstead Ave			

(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

W. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine*

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.