

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19927
Registrar's No. 5018

FILED JUN 4 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois		b. COUNTY 8120			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN Kerr Island			
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital		e. STREET ADDRESS (If rural, give location) 119 Dixon Road					
3. NAME OF DECEASED (Type or Print) a. (First) Charlie		b. (Middle)		c. (Last) Stainback			
4. DATE OF DEATH (Month) (Day) (Year) May 15, 1953		5. SEX Male <input checked="" type="checkbox"/>		6. COLOR OR RACE Negro			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 3		8. DATE OF BIRTH a 10-15-1879		9. AGE (In years last birthday) 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY unemployed		11. BIRTHPLACE (City and State or Foreign Country) Stanton, Tennessee			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Henderson Stainback		13b. MOTHER'S MAIDEN NAME Tilda ?			
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none			
17. INFORMANT'S SIGNATURE OR NAME Rommie Stainback		ADDRESS 119 Dixon					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Nephritis DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4222			
22. I hereby certify that I attended the deceased from 5/15, 1953, to 5/15, 1953, that I last saw the deceased alive on 5/15, 1953, and that death occurred at 7 P. M., from the causes and on the date stated above.							
23a. SIGNATURE [Signature] (Degree or title) M.D.		23b. ADDRESS 930 N 2ND A		23c. DATE SIGNED 5/17/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-18-53		24c. NAME OF CEMETERY OR CREMATORY Booker Washington			
24d. LOCATION (City, town, or county) Centerville, Illinois		24e. (State)					
DATE REC'D BY LOCAL REG. MAY 18 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE C. J. [Signature] ADDRESS 111 N. 13th			

5. Licensed Embalmer's Statement on Reverse Side

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.....
Signature of Student Embalmer

Signed..... *C. J. Nash*

Licensed Embalmer No. *2432*

P. O. Address *3847* Page

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.