

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **30161**
7838
Registrar's No. _____

FILED AUG 8 47115
BIRTH **47115** 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 Missouri b. COUNTY 2219	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 25 days		d. STREET ADDRESS (If rural, give location) 1010 Leffingwell	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		21 21	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Brenda	b. (Middle) Joyce	c. (Last) Lagrone	7		20 53
5. SEX Fem. 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6-25-53	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri 0	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Sadie Lagrone		14. NAME OF HUSBAND OR WIFE	

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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Lester M. Shepard 2601 N. Whittier	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth		II. OTHER SIGNIFICANT CONDITIONS			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) _____			
		DUE TO (c) _____			

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) 776 X	
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?	

22. I hereby certify that I attended the deceased from **6-25-1953**, to **7-20-1953** that I last saw the deceased alive on **7-20-1953**, and that death occurred at **10:00 P.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William H. Snickler, M. D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 7-22-53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 8-31-53		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. AUG 11 1953		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howland Mortuary Service 4104 Manchester Ave.	
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S.P. (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 _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.