THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 24 1953

State File No. 33618

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8348

1. PLACE OF DEATH
a. COUNTY: 1120 Hadley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis Mo
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1102 Hadley

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 2259
d. STREET ADDRESS (If rural, give location): 25 1102 Hadley 1102

3. NAME OF DECEASED (Type or Print): a. (First) Sammy b. (Middle) Earl c. (Last) LITTLE

4. DATE OF DEATH (Month) (Day) (Year): Aug 26 1953

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): N M

8. DATE OF BIRTH: 20 Jan 1918

9. AGE (In years last birthday): 35 — 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): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and State or Foreign Country): 9

12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: TOMMY LITTLE

13b. MOTHER'S MAIDEN NAME: Marlia Springfield

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 381-26-4566

17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Pearl a Nere Adams 1524 Eole

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Meningitis
DUE TO (c) (Cause unknown)

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 [X] NO [ ]

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): Sunday

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?: 3403

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 1005A m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M Quinn Deputy Coroner

23b. ADDRESS: 1300 Clark

23c. DATE SIGNED: 8/28/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 1 Sept 53

24c. NAME OF CEMETERY OR CREMATORY: Oakdale Cemetery

24d. LOCATION (City, town, or county) (State): St Louis County Mo

DATE REC'D BY LOCAL REG.: AUG 28 1953

REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Reliable Funeral Sys 4500 Newberry Ter

(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 Paul V. Freeman

Licensed Embalmer No. 4686

P. O. Address 4729 Hammett

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.