

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 30 1953

State File No. **37511**
Registrar's No. **10140**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 37511		Registrar's No. 10140				
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) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>						
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 1902 Bellglade								
3. NAME OF DECEASED (Type or Print) a. (First) Jim			b. (Middle) _____			c. (Last) Price			4. DATE OF DEATH (Month) (Day) (Year) 10 21 53			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH February 15, 1900		9. AGE (In years last birthday) 53	10. UNDER 1 YEAR Days 8	11. UNDER 1 HR. Hours 6	12. UNDER 1 HR. Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Scullin Steel Co.		11. BIRTHPLACE (City and State or Foreign Country) Tennessee			12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13a. FATHER'S NAME ?				13b. MOTHER'S MAIDEN NAME Lillian				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) No				16. SOCIAL SECURITY NO. 498-16-1125		17. INFORMANT'S SIGNATURE OR NAME Hospital Records						ADDRESS _____
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular Accident ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>						INTERVAL BETWEEN ONSET AND DEATH Undt.				
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X								
22. I hereby certify that I attended the deceased from 10-5 , 19 53 , to 10-21 , 19 53 , that I last saw the deceased alive on 10-21 , 19 53 , and that death occurred at 2:15 A.m. , from the causes and on the date stated above.												
23a. SIGNATURE E. B. Williams				(Degree or title) M.D.		23b. ADDRESS 2601 N. Whittier			23c. DATE SIGNED 10-23-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 1953		24c. NAME OF CEMETERY OR CREMATORY Oak Dale		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.						
DATE REC'D BY LOCAL HEALTH DEPT. OCT 24 1953		REGISTRAR'S SIGNATURE J. Earl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. RANDLE & SON 3133 Bell Ave.						

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.....
Signature of Student Embalmer

Signed, *S. J. Watson*.....

Licensed Embalmer No. *269*.....

P. O. Address *2769 Ohio*.....

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.