

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

18572-54
FILED MAR 31 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10040**
Registrar's No. **2677**

BIRTH NO. _____ 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 OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 9 hrs 10 mins	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Romer G. Phillips		d. STREET ADDRESS (If rural, give location) 27 3022 R. Franklin	

3. NAME OF DECEASED (Type or Print)	a. (First) _____	b. (Middle) _____	c. (Last) Furlow	4. DATE OF DEATH (Month) (Day) (Year) 3 10 54
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 3-10-54	9. AGE (In years last birthday) 9	# UNDER 1 YEAR Months _____	YEAR Days _____	# UNDER 10 HRS. Hours _____	Min. 10
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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	12. CITIZEN OF WHAT COUNTRY? 0
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13a. FATHER'S NAME (Separated)	13b. MOTHER'S MAIDEN NAME Gladie Vaughn	14. NAME OF HUSBAND OR WIFE
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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 Father M. Sherrard	ADDRESS 2601 N. Whittier
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth, neonatal 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) _____		
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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
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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?
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22. I hereby certify that I attended the deceased from **3-10-1954** to **3-10-1954** that I last saw the deceased alive on **3-10-1954**, and that death occurred at **1:10 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE William H. Swickler M.D. (Degree or title)	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 3-17-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE 3-31-54	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAR 24 1954	REGISTRAR'S SIGNATURE Joseph Smith	25. FUNERAL DIRECTOR'S SIGNATURE Roland-Aker Mortuary Service	ADDRESS _____
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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.