

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20386

BIRTH NO. 38603-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5111

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 town or CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 17hrs 10mins	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			d. STREET ADDRESS (If rural, give location) 2623 Delmar					
3. NAME OF DECEASED (Type or Print) Ann			a. (First)	b. (Middle)	c. (Last) Dent			
4. DATE OF DEATH 5 19 54		5. SEX 3 Fem.		6. COLOR OR RACE Negro				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0		8. DATE OF BIRTH 5-18-54		9. AGE (In years last birthday) 17 1/2				
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				
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Leola Dent				
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 (M. E. M. Sherrill PRP)		ADDRESS 2601 N. Whittier						
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, ashenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION 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.			INTERVAL BETWEEN ONSET AND DEATH		
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 776x				
22. I hereby certify that I attended the deceased from 5-18-19 54 to 5-19-19 54, that I last saw the deceased alive on 5-19-19 54, and that death occurred at 8:15 AM, from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) William N. Sunkler, M. D. 0			23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 5-26-54			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-30 54		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board				
24d. LOCATION (City, town, or county) St. Louis, Mo.		(State)						
DATE REC'D BY LOCAL REG. JUN 9 1954		REGISTRAR'S SIGNATURE J. Carl Smith mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.				

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.