

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24907**
Registrar's No. **6585**

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	
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	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1230 Walton Ave.,	
3. NAME OF DECEASED (Type or Print) a. (First) Charlie b. (Middle) c. (Last) McGhee		4. DATE OF DEATH (Month) (Day) (Year) July 13, 1954	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 3, 1899
9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Magee, Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Duncan McGhee		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Ora McGhee		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.		17. INFORMANT'S SIGNATURE OR NAME Ora McGhee ADDRESS 1230 Walton Ave.,	

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) Ruptured Appendix		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Appendectomy, Heat Stroke		Undt
*This does not mean the mode of dying, such as heart failure, asphyxiation, etc., or means the disease, injury, or condition which caused death.		ANTECEDENT CAUSES All other 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 551XF

22. I hereby certify that I attended the deceased from **July 8, 1954**, to **July 13, 1954**, that I last saw the deceased alive on **July 13, 1954**, and that death occurred at **7:25 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Carl Belle Smith, M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 7/16/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/19/54	24c. NAME OF CEMETERY OR CREMATORY Magee, Mississippi.
24d. LOCATION (City, town, or county) (State)		

DATE REC'D BY LOCAL REG. JUL 17 1954	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry ADDRESS 4202 Finney Ave.,
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WRITE PLAINLY—USING UNFAADING 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 James A. Carter

Licensed Embalmer No. 4681

P. O. Address St. Louis, Mo.

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