

FILED AUG 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25335**
Registrar's No. **6971**

BIRTH NO. **49024-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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	
c. LENGTH OF STAY (in this place) 30mins		d. STREET ADDRESS (If rural, give location) 2221 Cass	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		2. DATE OF DEATH (Month) (Day) (Year) 7 14 54	
3. NAME OF DECEASED (Type or Print) a. (First) Thomas		b. (Middle)	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX Undt.		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 7-13-54	
9. AGE (In years last birthday)		10. UNDER 1 YEAR Months	
11. UNDER 1 YEAR Days		12. UNDER 1 HR. Hours	
13. UNDER 1 HR. Mins. 30		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME	
13b. MOTHER'S MAIDEN NAME Mattie Thomas		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <i>Arthur W. Shrad</i>		ADDRESS 2601 N. Whittier	
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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth, neonatal death		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		DUE TO (b)	
<i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		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"/>		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? 7785		22. I hereby certify that I attended the deceased from 7-13- , 19 54 , to 7-14- , 19 54 that I last saw the deceased alive on 7-14- , 19 54 , and that death occurred at 12:15a m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <i>William H. Ankler</i> M. D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 7-21-54		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 7-31-54		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service	
25. DATE REC'D BY LOCAL REG. III 28 1954		26. REGISTERAR'S SIGNATURE <i>Carl Smith</i>	
27. FUNERAL DIRECTOR'S ADDRESS 1104 Manchester Ave. St. Louis 10, Mo.		(Licensed Embalmer's Statement on Reverse Side)	

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 with the above constitutes grounds for revocation of license.)

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