

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36117

Registrar's No. 8464

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8464				
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 checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 2731 Mill Street				2219		
3. NAME OF DECEASED (Type or Print) John			a. (First)		b. (Middle)		c. (Last) White			
4. DATE OF DEATH (Month) (Day) (Year) 9 14 54		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 12-31-1891		
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months _____		IF UNDER 24 HRS. Days _____		Hours _____		Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wall Washer			10b. KIND OF BUSINESS OR INDUSTRY Hotel			11. BIRTHPLACE (City and State or Foreign Country) Arkansas			12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Bob White			13b. MOTHER'S MAIDEN NAME Henrietta Hill			14. NAME OF HUSBAND OR WIFE Leona White				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 491-12-5176		17. INFORMANT'S SIGNATURE OR NAME Leona White				ADDRESS 2731 Mill Street		
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) Suppuration (non-traumatic) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Carcinoma of Trachea 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 checked="" type="checkbox"/> NO <input 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? 162x						
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:30 p. m. , from the causes and on the date stated above.										
23a. SIGNATURE Joseph M. [Signature]				23b. ADDRESS 1300 Clark				23c. DATE SIGNED 9/15/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-20-54		24c. NAME OF CEMETERY OR CREMATORY National Cemetery		24d. LOCATION (City, town, or county) (State) Jefferson Bks. Missouri				
DATE REC'D BY LOCAL REG. SEP 15 1954		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St.					

S.P. (Licensed Embalmer's Statement on Reverse Side)

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 *Fuller E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address *Stans 13*

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.