

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42946

BIRTH NO. 84261-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10431

|  |                           |  |                              |
|--|---------------------------|--|------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           | 2. USUAL RESIDENCE (where deceased lived. If institution: residence before admission)<br>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  |                           | e. LENGTH OF STAY (in days) 2 days   |                              |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) b. (Middle) c. (Last)<br>Whitfield  |                           | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br>10 15 54   |                              |
| 5. SEX<br>Fem. 3   | 6. COLOR OR RACE<br>Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0   | 8. DATE OF BIRTH<br>10-13-54 |
| 9. AGE (In years last birthday) 2  |                           | 10. IF UNDER 1 YEAR Months Days 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)<br>Missouri 0  |                           | 12. CITIZEN OF WHAT COUNTRY?   |                              |
| 13a. FATHER'S NAME   |                           | 13b. MOTHER'S MAIDEN NAME<br>Helen Williams  |                              |
| 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<br>Walter M. Shepard, Sr.  |                           | ADDRESS<br>2601 N. Whittier  |                              |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. Term birth, neonatal death |                              |
| 19a. DATE OF OPERATION   |                           | 19b. MAJOR FINDINGS OF OPERATION   |                              |
| 20. AUTOPSY?<br>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?<br>7600   |                           |  |                              |
| 22. I hereby certify that I attended the deceased from 10-13-54 to 10-15-19 54, that I last saw the deceased alive on 10-15-54, and that death occurred at 5:45p m., from the causes and on the date stated above.             |                           |  |                              |
| 23a. SIGNATURE<br>William H. Sinkler M. D.   |                           | 23b. ADDRESS<br>2601 N. Whittier   |                              |
| 23c. DATE SIGNED<br>10-20-54   |                           |  |                              |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>11-30-54  |                           | 24b. DATE<br>11-30-54  |                              |
| 24c. NAME OF CEMETERY OR CREMATORY<br>Anatomical Board   |                           | 24d. LOCATION (City, town, or county) (State)<br>St. Louis, Mo.  |                              |
| DATE REC'D BY LOCAL REG.<br>NOV 17 1954  |                           | REGISTRAR'S SIGNATURE<br>Carl Smith Mo   |                              |
| FUNERAL DIRECTOR'S SIGNATURE<br>Rowland-Aker Mortuary Service  |                           | ADDRESS<br>4104 Manchester Ave<br>St. Louis 10, Mo.  |                              |

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

(Licensed Embalmer's Statement on Reverse Side Louis 10, Mo.)

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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 with the above constitutes grounds for revocation of license.)

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