

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9898**
Registrar's No. **2856**

FILED APR 11 1955

BIRTH NO. **18507-55** 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 OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 days	c. CITY OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 4115 Fairfax			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			d. STREET ADDRESS (If rural, give location) 4115 Fairfax					
3. NAME OF DECEASED (Type or Print) Leanna		a. (First)	b. (Middle)	c. (Last) McDaniel	4. DATE OF DEATH (Month) (Day) (Year) 2 26 55			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 2-24-55	9. AGE (In years last birthday)	F UNDER 1 YEAR Days	F UNDER 24 HRS. Hours	F UNDER 1 MIN. Mins.
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		12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME Timmie L. McDaniel			13b. MOTHER'S MAIDEN NAME Arlene Gloss		14. NAME OF HUSBAND OR WIFE Mrs.			
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 ADDRESS <i>Madeline Susan C.R.L.</i> 2601 N. Whittier				
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) Premature birth, neonatal death								
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			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 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? 7:35				
22. I hereby certify that I attended the deceased from Feb. 24 1955 , to Feb. 26 1955 , that I last saw the deceased alive on Feb. 26 1955 , and that death occurred at 7 a. m. , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <i>William H. Sinkler</i> M. D.			23b. ADDRESS 2601 N. Whittier			23c. DATE SIGNED 3-7-55		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 3-31-55	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. MAR 30 1955		REGISTRAR'S SIGNATURE <i>Charles Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Newland Mortuary Service</i>				

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.