

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13640

3251

BIRTH NO. 26410-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3251

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) 9hrs. 10 min.		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			d. STREET ADDRESS (If rural, give location) 21 2350 Biddle			
3. NAME OF DECEASED (Type or Print) a. (First) Mack			b. (Middle)		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) 4 1 55						
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 3-31-55		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 9 10	
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? 0		13a. FATHER'S NAME Willie Mack		13b. MOTHER'S MAIDEN NAME Jacquelyn Roland		
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 Arthur M. Sherard		ADDRESS C.R.L. 2601 N. Whittier				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION "DIRECTLY LEADING TO DEATH" (a) Premature birth, neonatal death 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 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? 1735		
22. I hereby certify that I attended the deceased from 3-31-1955 to 4-1-1955 that I last saw the deceased alive on 4-1-1955 , and that death occurred at 6:20 a.m. , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) William H. Linkler, M.D.			23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 4-6-55	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-30-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.						
DATE REC'D BY LOCAL REG. APR 12 1955		REGISTRAR'S SIGNATURE J. C. Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howland - Howland Mortuary Service		

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.