No. 300
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FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31272

BIRTH NO. 60541-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7801

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2901 Lucas Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 2901 Lucas Avenue 221/0

3. NAME OF DECEASED (Type or Print) a. (First) Sheron b. (Middle) c. (Last) Munson

4. DATE OF DEATH (Month) 9 (Day) 3 (Year) 55

5. SEX Female
6. COLOR OR RACE Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant
8. DATE OF BIRTH 7-21-55
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 1 Days 12 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Carlos Munson
13b. MOTHER'S MAIDEN NAME Essie Taylor
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Infant
17. INFORMANT'S SIGNATURE OR NAME Carlos Munson ADDRESS 2901 Lucas Avenue

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Interstitial Pneumonitis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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 492+
20. AUTOPSY? YES ☑ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

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 705A m., from the causes and on the date stated above.*

23a. SIGNATURE Joseph M Queen Deputy Coroner (Degree or title)
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 9/6/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-6-55
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

DATE REC'D BY LOCAL REG. SEP 6 1955
REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.
25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home, Inc. ADDRESS 2820 Stoddard St.

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed...Fulton E. Culk

Licensed Embalmer No. 41

P. O. Address ...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.