

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38352**
10441
Registrar's No. _____

FILED DEC 12 1955
BIRTH NO. **81199-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) 11 days		e. STREET ADDRESS (If rural, give location) 11 1406 N. Market		21190	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Barbara		b. (Middle) Jean		c. (Last) Herbert	
5. SEX Fem.		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH 10-15-55		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months	
11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY?		13. IF UNDER 24 HRS. Hours Min.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Thelma Herbert		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 Mrs. E. M. Howard	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis Bilateral, Congenital 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 Premature birth		ADDRESS 2601 N. Whittier INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 762.5		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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-15- , 19 55 , to 10-26- , 19 55 , that I last saw the deceased alive on 10-26-n. 19 66 , and that death occurred at 12:45 p. from the causes and on the date stated above.					
23a. SIGNATURE William A. Miller		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 11-4-55	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 11-30-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Bldg.	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service		ADDRESS	

DATE REC'D BY LOCAL REG. **NOV 30 1955** REGISTRAR'S SIGNATURE **[Signature]** (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.....

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 embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.