

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1955

State File No. **38705**

BIRTH NO. **82662-55**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **10462**

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)
20 mins

c. CITY OR TOWN **St. Louis**

d. Is Residence within limits of a city or incorporated town?
Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION
Homer G. Phillips

STREET ADDRESS (If rural, give location)
19 4270 Delmar

3. NAME OF DECEASED
a. (First) b. (Middle) c. (Last)
Page

4. DATE OF DEATH (Month) (Day) (Year)
10-17-55

5. SEX
Male

6. COLOR OR RACE
Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH
10-17-55

9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 14 HRS. Hours Mins
20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country)
Missouri

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME
Izell Page

13b. MOTHER'S MAIDEN NAME
Ada Cotton

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 ADDRESS
Mrs E. M. Sheridan 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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Premature birth, neonatal death**

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

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
7735

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
776 x

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) (Min)

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 **10-17-**, 1955, to **10-17-**, 1955, that I last saw the deceased alive on **10-17-**, 1955, and that death occurred **9-20a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
William A. Hinkley, M. D.

23b. ADDRESS
2601 N. Whittier

23c. DATE SIGNED
10-19-55

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE
11-30-55

24c. NAME OF CEMETERY OR CREMATORY
Anatomical Board

24d. LOCATION (City, town, or county) (State)
St. Louis, Mo.

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE
NOV 30 1955
J. Carl Smith

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Field Mortuary Service

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.