

THE DIVISION OF HEALTH OF MISSOURI

FILED MAR 22 1956

STANDARD CERTIFICATE OF DEATH

1003

State File No. 10714

BIRTH NO. 18624-56

REG. DIST. NO. 318

PRIMARY REG. DIST. NO.

Registrar's No. 2039

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)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hos.					
3. NAME OF DECEASED (Type or Print) a. (First) Delcencia b. (Middle) Thelma c. (Last) Foster			4. DATE OF DEATH (Month) (Day) (Year) Feb. 26, 1956		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH Feb. 24, 1956		9. AGE (In years last birthday) 2		10. IF UNDER 1 YEAR Months Days Hours Min.	
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) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Wylie Foster		13b. MOTHER'S MAIDEN NAME Beatrice Johnson	
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) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Wylie Foster		ADDRESS 5022 St. Louis Ave			
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) Suffocation from aspiration of blood; aspirated during feeding at home on February 26, 1956 exact. II. OTHER SIGNIFICANT CONDITIONS Disease Unknown. INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) St. Louis (COUNTY) Mo (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 26 56 ? m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? ADD	
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 10:40 p.m., from the causes and on the date stated above.					
23a. SIGNATURE (Sign in ink, give name or title) Frank M. Quinn		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 2/27/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-27-56		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo		24e. DATE REC'D BY LOCAL REG. FEB 27 1956		24f. REGISTRAR'S SIGNATURE J. Carl Smith MO	
25. FUNERAL DIRECTOR'S SIGNATURE English Undertaking Co.		ADDRESS 1123 N Taylor			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 e
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Was not Embalmed
Signed *Murray Swann*
Licensed Embalmer No.....

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.