

Health, Welfare, Public Service  
 300 1-56  
 3-18-94  
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in item 18. Must use only standard nomenclature in item 18. No symptoms will be listed. Coroner cannot certify to a death due to natural causes.

STANDARD CERTIFICATE OF DEATH

FILED OCT 16 1956

35807  
 STATE FILE NUMBER  
 8825

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>St. Louis</b> TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>2927 Lucas</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Jesse Lee</b>			4. DATE OF DEATH Month <b>9</b> Day <b>22</b> Year <b>56</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 3-1894</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maidance man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Opt. House</b>	11. BIRTHPLACE (City and state or country) <b>Mississippi</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		17. INFORMANT <b>Melva Lee</b> Address <b>2729 Lucas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic Insufficiency with Auricular Fibrillation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>42:1</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease:</b>		19. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____, Month _____, Day _____, Year _____ a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <b>9-12-56</b> to <b>9-22-56</b> and last saw her/him alive on <b>9-22-56</b> Death occurred at <b>8:40 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>Hugh Waters</b> (Degree or title) <b>M. D.</b>	22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>9-23-56</b>

23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-27-1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, County Mo</b>
24. FUNERAL DIRECTOR <b>English Uddt Co.</b> ADDRESS <b>1123 Taylor</b>	25. DATE RECD. BY LOCAL REG. <b>SEP 25 1956</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith m.d.</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1921 9 33E

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 *William R. Halla*

Licensed Embalmer No. *149*

P. O. Address *45 5th St  
St Louis*

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.