

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14553

FILED MAY 10 1957

STATE FILE NUMBER
3940

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

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Illinois</i> b. COUNTY <i>St. Clair</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>East St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Missouri Pacific</i>			Length of stay in lb	d. STREET ADDRESS <i>329</i>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>WAYNE</i> Middle Last <i>CHESTER</i>				4. DATE OF DEATH Month <i>April</i> Day <i>24</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 14, 1894</i>	9. AGE (In years last birthday) <i>63</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>GM & O Railroad</i>	11. BIRTHPLACE (City and state or country) <i>Meridian, Mississippi</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>WARREN CHESTER</i>				14. MOTHER'S MAIDEN NAME <i>JOSIE DAVIS</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Vallie Dreker</i> Address <i>35-B John Robinsion East St. Louis, Ill.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural Hematoma</i>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Time, Place, Cause and manner of same could not be determined</i>			9369	48		
20c. TIME OF INJURY Hour <i>3:33</i> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <i>383</i> COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <i>6:5A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>James M Kelly Deputy Registrar</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>4-25-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>4/25/57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Booker Washington</i>		23d. LOCATION (City, town, or county) (State) <i>Centreville Township, Ill.</i>			
24. FUNERAL DIRECTOR <i>Marion G. Grier</i> ADDRESS <i>2114 Mo. Ave. East St. Louis, Ill.</i>			25. DATE RECD. BY LOCAL REG. <i>APR 25 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
S. 300 v. 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1951

1951

318

1951 E MDP

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 *Ben H. Baldwin*

Licensed Embalmer No. 2420

P. O. Address 721 N. 26th

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.