

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29903

STATE FILE NUMBER

FILED SEP 4 1957

318

1003

7665

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

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 27 Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 926 Academy	
3. NAME OF DECEASED (Type or print) First Middle Last T. L. Pratt		4. DATE OF DEATH Month Day Year 8 12 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19 1920
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		9. AGE (In years last birthday) 37	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Arthur Pratt		14. MOTHER'S MAIDEN NAME Burlare Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If up, give war or dates of service) No		16. SOCIAL SECURITY NO. 430-50 0582	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Insufficiency - Arteriolar nephrosclerosis 4422		INTERVAL BETWEEN ONSET AND DEATH 1 da 27m.	
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. 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 COUNTY STATE	
21. Attended the deceased from 4/12 5 to 8/13 57 and last saw him alive on 4/13 57 Death occurred at 9:35 A m on the date stated above; and to the best of my knowledge, from the causes stated.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE L R Wentzel (Degree or title), M.D.		22b. ADDRESS 2726 Chippewa	
22c. DATE SIGNED 8-13-57		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE Aug 16/57		23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem	
23d. LOCATION (City, town, or county) (State) St Louis MO		24. FUNERAL DIRECTOR F. A. Green 4214 Delmar	
25. DATE RECD. BY LOCAL REG. AUG 16 57		26. REGISTRAR'S SIGNATURE Carl Smith MO	

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

MBS

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 *F. A. Shear*.....

Licensed Embalmer No. *29*

P. O. Address *4214 Dolan*.....

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.