

FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30044**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7808**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY OR TOWN <u>St. Louis</u>	c. LENGTH OF STAY (in this place) <u>18 days</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital 1703 730 Cozans Street</u>		e. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Charlie Glenn Stallion</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 17 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>July 20, 1955</u>
9. AGE (In years last birthday) <u>2 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>
11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert Lee Stallion</u>		13b. MOTHER'S MAIDEN NAME <u>Aune Robinson</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Jane Henriksen</u> ADDRESS <u>500 S. Kingshighway</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intra cranial hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute Lymphocytic leukemia</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>204.0</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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 (Month) (Day) (Year) (Hour) OF INJURY _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>7-31</u> , 19 <u>57</u> , to <u>8-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-17</u> , 19 <u>57</u> , and that death occurred at <u>3:25 A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>D.S. Thurston</u> (Degree or title) _____		23b. ADDRESS <u>500 S. Kingshighway</u>	
23c. DATE SIGNED <u>8-17-57</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24b. DATE <u>8-22-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellis Funeral Home, Inc.</u> ADDRESS <u>2820 Stoddard St.</u>	
DATE REC'D BY LOCAL REG. <u>AUG 20 57</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>	

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 *Fulton E. Culkin*.....

Licensed Embalmer No. *419*.....

P. O. Address *Shore*.....

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.