. Health,
& Welfare
S. Public
h Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 17 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33968

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8215

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer Phillips Hospital — Length of stay in 1b: 2 or 3 dys

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 3145 New Ashland — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: DE WITT — Middle: — Last: PENNY

4. DATE OF DEATH: Month: 8 Day: 30 Year: 57

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/7/1894
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months 11 Days 23 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (disabled)
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (City and state or country): Commerce, Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: James Dewitt
14. MOTHER'S MAIDEN NAME: Malenda Broo
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mable Penny, 3145 New Ashland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Several years
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): 420.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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

21. I attended the deceased from 12/18/56 to 8/29/57 and last saw him alive on 8/28/57
Death occurred at 2:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. C. Walles (Degree or title) M.D.
22b. ADDRESS: 505 University Club Bldg.
22c. DATE SIGNED: 8/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9/5/57
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR: Charles J. Gates — ADDRESS: 4107 Finney
25. DATE RECD. BY LOCAL REG.: SEP 3 '57
26. REGISTRAR'S SIGNATURE: Earl Smith MD
MDB

(Licensed Embalmer's Statement on Reverse Side)

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..Guyton Swan

Licensed Embalmer No..45

P. O. Address 4107 Finne

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.