

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37819

FILED NOV 4 1957

STATE FILE NUMBER

10149

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

Health,
& Welfare
Public
Service

300
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

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4725 Maffitt Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ezell Middle Last Nance			4. DATE OF DEATH Month 10 Day 27 Year 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 22 Feb 1888
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		9b. KIND OF BUSINESS OR INDUSTRY Hydraulic Bireck	9c. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		100. KIND OF BUSINESS OR INDUSTRY Hydraulic Bireck	11. BIRTHPLACE (City and state or country) Mississippi 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Aleen Nance		14. MOTHER'S MAIDEN NAME Annie Nance	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 489-039-465	17. INFORMANT Address Mrs Magnolia Nance 4725 Maffitt Ave
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancytopenia DUE TO (b) Miliary Tuberculosis, involving Liver and Bone Marrow DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 019.2			INTERVAL BETWEEN ONSET AND DEATH undet.
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 _____ 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 10-6-57 to 10-27-57 and last saw xxx him alive on 10-27-57 Death occurred at 1:50 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Sydney A. Drasen M.D. (Degree or title)		22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 10-28-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/30/57	23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo
24. FUNERAL DIRECTOR Herman J. Smith ADDRESS 4247/w Labadie		25. DATE RECD. BY LOCAL REG. OCT 29 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.

(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 embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision...

Student _____
Signature of Student Embalmer

Signed *W. Claude Gordon*

Licensed Embalmer No. *348*

P. O. Address *4575 Old*

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.