

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42511

STATE FILE NUMBER

318

1003

10834

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in 1b	d. STREET ADDRESS <b>2505 N. Sarah</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Anthony Rice</b>			4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Miss</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ruffin Rice</b>			14. MOTHER'S MAIDEN NAME <b>Kattie ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes #1</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Carry Whitfield 2505 N Sarah</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cirrhosis of Liver</b> DUE TO (c) <b>581.0</b>					INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>A. S. H. D., Cardiac hypertrophy</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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. I attended the deceased from <b>11-6-57</b> to <b>11-8-57</b> and last saw <b>him</b> alive on <b>11-8-57</b> Death occurred at <b>7:10 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Lydney A. Isaac, M.D.</b>			22b. ADDRESS <b>2601 Whittier Street</b>		22c. DATE SIGNED <b>11-11-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov 14/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cem</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis County Mo</b>
24. FUNERAL DIRECTOR <b>F. A. Green 4214 Delmar</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 13 57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

S. 300  
y. 1-56Health,  
& Welfare  
Public  
Service

Missouri

St. Louis

State of Missouri

Robert G. Phillips

27 3 11

Rice

Anthony

27

x

Macro

Miss

ADU

STATEMENT BY LICENSED EMBALMER

under

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *F. A. Green*

Licensed Embalmer No. 296

11-8-27

work

11-8-27

11-8-27

P. O. Address 7214 Delon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F

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.