

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

46203
STATE FILE NUMBER
12628

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

S. 300
v. 1-57

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 Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2119 3602a Finney	
3. NAME OF DECEASED (Type or print) William Bill Pettigrew		4. DATE OF DEATH Month 12 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 Oct. 17, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Washer (at Laundry)		10b. KIND OF BUSINESS OR INDUSTRY Broadway Laundry	11. BIRTHPLACE (City and state or country) Decaterville, Ill
13a. FATHER'S NAME James Pettigrew		13b. MOTHER'S MAIDEN NAME Ella Laster	14. NAME OF HUSBAND OR WIFE Augusta Pettigrew
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No.		16. SOCIAL SECURITY NO. 357-09-3604	17. INFORMANT Address Augusta Pettigrew 3602(a) Finney
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage (undetermined Origin)			INTERVAL BETWEEN ONSET AND DEATH undet.
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) Cholecystitis - Cholelithiasis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 11-22-57 to 12-27-57 and last saw him alive on 12-27-57 Death occurred at 3:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Herschel Hamilton, M.D.		22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 12-27-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan 2, 1958	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetary	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Wm. Smith 4019 Washington		25. DATE RECD. BY LOCAL REG. DEC 30 57	26. REGISTRAR'S SIGNATURE J. Carl Smith

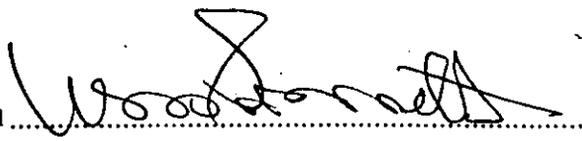
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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  _____

Licensed Embalmer No. 4371
P. O. Address St. Louis, Mo.

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.