

pt. Health,  
c. & Welfare  
S. Public  
alth Service

V. S. 300  
ev. 1-57

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.  
Security and medical certificate forms - separate - inquirer required by 193. (a) MOKS 1945.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FILED JAN 17 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

77520  
STATE FILE NUMBER  
12767  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

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	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4977 Lotus	
Length of stay in lb Unknown		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Will Davis			4. DATE OF DEATH Month Day Year 12 30 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 12-27-89
9. AGE (In years last birthday) 68		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) Tenn.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Will Davis	
13b. MOTHER'S MAIDEN NAME Unk		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 492-01-2495	17. INFORMANT Hospital Record
Address 2601 Whittier		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus with Extension to Aorta and Bronchus Interval BETWEEN ONSET AND DEATH undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } 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) Pneumonia, Aspiration 150x	
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 <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 12-21-57 to 12-30-57 and last saw him alive on 12-30-57 Death occurred at 5:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22. SIGNATURE Henschell Hamilton, M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 1-2-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 1-6-1958		23c. NAME OF CEMETERY OR CREMATORY Greenwood	
23d. LOCATION (City, town, or county) St. Louis, Co Mo		24. FUNERAL DIRECTOR J.H. Ramble & Son 3133 Bell Ave	
25. DATE RECD. BY LOCAL REG. JAN 4 '58		26. REGISTRAR'S SIGNATURE Earl Smith md	

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 *Esther J. Harris*

Licensed Embalmer No. *4458*

P. O. Address *4181 Washin*

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.