

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **58-016636**

No. 300
10-48

FILED APR 18 1958

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3685**

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|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY | | | |
| b. CITY OR TOWN St Louis | | c. LENGTH OF STAY (in this place) | | c. CITY OR TOWN St Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 27 Homer L. Phillip Hospital | | e. STREET ADDRESS (If rural, give location) 4314 Garfield Ave. | | | |
| 3. NAME OF DECEASED (Type or Print) Beverly Jean Wynn | | | 4. DATE OF DEATH (Month) (Day) (Year) 3 30 - 1958 | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single | |
| 8. DATE OF BIRTH 2-10-1953 | | 9. AGE (In years last birthday) 5 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | |
| 10a. USUAL OCCUPATION | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME William M. H. Wynn | | 13b. MOTHER'S MAIDEN NAME Dorothy Bruce | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT'S SIGNATURE OR NAME William H. Wynn | | ADDRESS 4314 Garfield | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |
| 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sickle Cell Anemia | | 2. ANTECEDENT CAUSES | | INTERVAL BETWEEN ONSET AND DEATH | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | DUE TO (b) _____ | | | |
| DUE TO (c) 292.6 | | 11. OTHER SIGNIFICANT CONDITIONS | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 19c. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 20. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE Gabriel F. Taylor | | 23b. ADDRESS 1300 Clark | | 23c. DATE SIGNED 4.1.58 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 4/4/58 | | 24c. NAME OF CEMETERY OR CREMATORY Washington Park | |
| 24d. LOCATION (City, town, or county) St Louis Co. | | 24e. (State) MO. | | DATE REC'D BY LOCAL HEALTH OFFICE APR 1 1958 | |
| REGISTRAR'S SIGNATURE J. C. Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE Boyd Funeral Home | | ADDRESS 3704 Kinney | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *H. L. Lauder Gordon*

Licensed Embalmer No. *34*

P. O. Address *4575th*

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.