

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030327
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7572

300
1-57

1. PLACE OF DEATH a. COUNTY ST. LOUIS - MO		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 - MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 746 Aubert	

3. NAME OF DECEASED (Type or print) First John Middle Last Drake			4. DATE OF DEATH Month 8 Day 1 Year 58		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-1899	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MC. KENZIA - TENN	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME BOOKER - DRAKE	13b. MOTHER'S MAIDEN NAME ADA DRAKE	14. NAME OF HUSBAND OR WIFE ON NON
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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. 486-16-4839	17. INFORMANT MABLE SCOTT NEACE - 4512 NEWBERRY TR	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) genty nephritis.		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) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) genty arthritis		

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.)
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20c. TIME OF INJURY Hour _____ 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 594X	COUNTY	STATE
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21. I attended the deceased from 7-1-58 to 8-1-58 and last saw ^{him} alive on 8-1-58 Death occurred at 9:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Will. Draser (Degree or title) , M.D.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 8-1-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVE	23b. DATE 8-6-1958	23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEMETRY	23d. LOCATION (City, town, or county) (State) COUNTY - MO
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24. FUNERAL DIRECTOR PEASTON FURNEL HOME 3615 EASTON	25. DATE RECD. BY LOCAL REG. AUG 4 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

W. A. B.

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 *Leroy V. Pennister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.