

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038090

STATE FILE NUMBER

Registrar's No. 10144

FILED OCT 30 1958

Registration District No. 318 Primary Registration District No. 1003

300
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 OR TOWN St. Louis	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in lb 27	d. STREET ADDRESS (If outside, give location) 4715 St. Louis
3. NAME OF DECEASED (Type or print) John Parker		First Middle Last	4. DATE OF DEATH Month 10 Day 17 Year 58
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1895
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	11. BIRTHPLACE (City and state or country) ALA.	12. CITIZEN OF WHAT COUNTRY? USA
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.	17. INFORMANT MORROW ROBINSON 2519 NO NEWSTEAD Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerosis			
DUE TO (c) 332x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Prostatic Hypertrophy.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 9-22-58 to 10-17-58 and last saw him alive on 10-17-58 Death occurred at 1:40 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. A. Innes (Degree or title)		22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 10-21-58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10-24-58	23c. NAME OF CEMETERY OR CREMATORY GREEN WOOD	23d. LOCATION (City, town, or county) (State) St. Louis County MO
24. FUNERAL DIRECTOR HOWARD & GLENN 4319 DEL MAR.		25. DATE RECD. BY LOCAL REG. OCT 23 1958	26. REGISTRAR'S SIGNATURE Carl Smith MO

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MISSOURI

St. Louis

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 _____

Signed *Arthur L. Heilbard*

Signature of Student Embalmer

30-71-71

Licensed Embalmer No. 4221

P. O. Address 3100 Eastman

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.