

Health,
Welfare
Public
Service

8

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046255
STATE FILE NUMBER
12539

318

1003

53 JAN 12 1959 Registration District No. Primary Registration District No. Registrar's No.

300
1-57

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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 (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Inside Limits Yes <input 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) 2219 2210 Carr | |
| Length of stay in lb | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|---|----------------------------------|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Oliver Middle Last Savage | | | 4. DATE OF DEATH Month 12 Day 23 Year 58 | | |
| 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 8-30-1992 | | 9. AGE (In years last birthday) 76 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (City and state or country) Natchez Miss. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A |

| | | | | | |
|--|--|--|--|--|--|
| 13a. FATHER'S NAME Williams Savage | | 13b. MOTHER'S MAIDEN NAME Ange line Calvin | | 14. NAME OF HUSBAND OR WIFE Bulah Savage | |
|--|--|--|--|--|--|

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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. UNKNOWN | 17. INFORMANT Bulah Savage | Address 2210 Carr |
|--|---|--------------------------------------|-----------------------------|

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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) Uremia | | | 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) _____ 600X | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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|---|--|------------------------------|--|--------|-------|
| 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 _____ 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 **11-15-58**, to **12-23-58** and last saw ^{him} alive on **12-23-58**
Death occurred at **5:40 P** m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | |
|---|---|-------------------------------------|
| 22a. SIGNATURE H. G. Innes (Degree or title) M.D. | 22b. ADDRESS 2601 Whittier Street | 22c. DATE SIGNED 12-26-58 |
|---|---|-------------------------------------|

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|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12-29-58 | 23c. NAME OF CEMETERY OR CREMATORY Greenwood | 23d. LOCATION (City, town, or county) (State) St Louis County - MO |
|--|------------------------------|--|--|

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|---|------------------------------|---|---|
| 24. FUNERAL DIRECTOR Hill & Radford | ADDRESS 1713 Grand | 25. DATE RECD. BY LOCAL REG. DEC 27 '58 | 26. REGISTRAR'S SIGNATURE Carl Smith - MD |
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 U. Darnist*

Licensed Embalmer No. *4523*
P. O. Address *4251 Wash*

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.