

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002809
STATE FILE NUMBER
2 591

FEB 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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-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	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4557 Page	
3. NAME OF DECEASED (Type or print) First Emanuel Middle F. Last Champion		4. DATE OF DEATH Month 1 Day 15 Year 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee - City of St. Louis, Mo.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 52
11. BIRTHPLACE (City and state or country) St. Paul, Minnesota		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Gus Champion		13b. MOTHER'S MAIDEN NAME Lottie Brooks	
14. NAME OF HUSBAND OR WIFE None		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. 487-26-2191		17. INFORMANT Robert Champion Address 4359 St. Ferdinand	
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 DUE TO (b) Arteriosclerosis DUE TO (c) 442X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH undet.
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 _____ to _____ and last saw him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) A. G. Innes, M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 1-15-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-20-59		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo	
24. FUNERAL DIRECTOR Peoples Und. Co. 3100 Franklin Av.		25. DATE RECD. BY LOCAL REG. JAN 17 1959	
26. REGISTRAR'S SIGNATURE J. Carl Smith - MD			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *H. Charles Jones*

Licensed Embalmer No. *3489*
P. O. Address *4575 Wilshire*

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.