Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002947
STATE FILE NUMBER

24

FILED FEB 10 1959

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 147

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN St. Louis, Mo. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) D.O.A. Homer Phillips — Length of stay in Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 1905 Carr Street — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Michail (Mikel) Middle Last Franklin

4. DATE OF DEATH Month January Day 4 Year 1959

5. SEX Male

6. COLOR OR RACE Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH Mar. 4, 1949

9. AGE (In years last birthday) 9 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (City and state or country) Little Rock, Arkansas

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME James Franklin

13b. MOTHER'S MAIDEN NAME Lucille McGowan

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)

16. SOCIAL SECURITY NO. none

17. INFORMANT Lucille Franklin — Address 1905 Carr St. - Apt. 307

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Suffocation;

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I. Fractured shaft while playing on Apartments Project about 830 p.m. on January 4th, 1959.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☒ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II above 18.)

20c. TIME OF INJURY Hour 830 p.m. Month, Day, Year 1. 4 59

800 E912.022

20d. INJURY OCCURRED WHILE AT WORK ☐ **NOT WHILE AT WORK** ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Apartment

20f. CITY, TOWN, OR LOCATION St Louis — **COUNTY** — **STATE** Mo.

21. I attended the deceased from 213 to ___ and last saw her/him alive on ___

Death occurred at 830 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph T. Quinn (Degree or title) Deputy Coroner

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 1/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 1-10-59

23c. NAME OF CEMETERY OR CREMATORY Greenwood

23d. LOCATION (City, town, or county) St. Louis (State) Mo.

24. FUNERAL DIRECTOR C. P. Rooney — **ADDRESS** 1221 N. Grand Blvd.

25. DATE RECD. BY LOCAL REG. JAN 6 59

26. REGISTRAR'S SIGNATURE Carl Smith MD

MDB

(Licensed Embalmer's Statement on Reverse Side)

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 Milvin Blackburn

Licensed Embalmer No. 396

P. O. Address 1221 N

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.