

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011128

FILED MAR 27 1959

STATE FILE NO. 2-2491
REGISTRATION DISTRICT NO. Primary REGISTRATION DISTRICT NO.

Registration District No. Primary Registration District No.

300
-57
28
72
0

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) 4204 Evans	
3. NAME OF DECEASED (Type or print) Ishmel Lee		4. DATE OF DEATH Month 3 Day 7 Year 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		11. BIRTHPLACE (City and state or country) New Orleans, La.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give dates of service) No		16. SOCIAL SECURITY NO. 497-09-9459	17. INFORMANT Address Mrs. Ruby Banks 4204 W. Evans
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) Arteriosclerosis			undet.
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) Hypertensive vascular disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 2-17-59 to 3-7-59 and last saw him ^{her} alive on 3-7-59 Death occurred at 9:45 P on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. G. Frazer (Degree or title) M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 3-9-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/12/1959	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Charles J. Gates ADDRESS 4107 Finney		25. DATE RECD. BY LOCAL REG. MAR 11 59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

REPRODUCED BY THE BUREAU OF STATISTICS

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 *Guyton Swan*

Licensed Embalmer No. *458*

P. O. Address *4107*

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.