

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011234

STATE FILE NUMBER

2-2529

FILED MAR 25 1959

Registration District No. Primary Registration District No.

Register No.

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) 2619 Dayton	

3. NAME OF DECEASED (Type or print) First William Middle Naylor Last			4. DATE OF DEATH Month 2 Day 16 Year 59		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years, months, days) 50	IF UNDER 1 YEAR Months 7 Days	IF UNDER 24 HRS Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) unknown	12. CITIZEN OF WHAT COUNTRY? unknown
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE unknown
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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) unknown	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address Mrs. May D. Jett, R.R.L. 2601 Whittier St.
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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) Subarachnoid Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH undet.
DUE TO (b) Ruptured Congenital Aneurysm		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 330x		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.)
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20c. TIME OF INJURY Hour 3:35 Month, Day, Year 2-7-59	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 St. Louis, Mo.
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21. I attended the deceased from 2-7-59 to 2-16-59 and last saw XX him alive on 2-16-59 Death occurred at 4:35 A m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE J.A. Inasa (Degree or title) 0	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 3-4-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Rowland Aker Mortuary Service	23b. DATE 3-31-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR'S ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.	25. DATE RECD. BY LOCAL REG. MAR 12 '59	26. REGISTERER'S SIGNATURE Miss Pearl Smith, M.D.
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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

Licensed Embalmer No.....

P. O. Address.....

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.