

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015661

STATE FILE NUMBER

FILED MAY 14 1959

Registration District No. _____

Primary Registration District No. _____

Registered No. **24310**

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. Phillipss		d. STREET ADDRESS (If outside, give location) 3636 Page	
3. NAME OF DECEASED (Type or print) First Luvenia Middle Sanders Last Sanders		4. DATE OF DEATH Month 4 Day 30 Year 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 15, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		11. BIRTHPLACE (City and state or country) Covington, Tennessee	
13a. FATHER'S NAME Daniel Farrow		14. NAME OF HUSBAND OR WIFE Dead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Mamie Hayes 5132 Palm Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Meningitis (Organism Undetermined)			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) _____			340.3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <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 4-14-59 to 4-30-59 and last saw her alive on 4-30-59 Death occurred at 3:10 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul A. Larson M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 5-1-59		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/4/59	
23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR ADDRESS C.W. Roberts Und. Co 1416 N. Taylor Ave		25. DATE RECD. BY LOCAL REG. MAY 2 '59	
26. REGISTRAR'S SIGNATURE Kearl Smith M.D. cum			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

00-57

MISSOURI DEPARTMENT OF HEALTH - DIVISION OF HEALTH RECORDS - ST. LOUIS, MISSOURI

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 James A. Sartin
Licensed Embalmer No. 4601
P. O. Address St. Louis

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.