

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015899

STATE FILE NUMBER
2 3971

FILED MAY 6 1959 Registration District No. Primary Registration District 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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2220 Carr Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) John Wallace			4. DATE OF DEATH Month 4 Day 18 Year 59		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 5, 1904	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Tenn	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Soffie ?	14. NAME OF HUSBAND OR WIFE
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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) No	16. SOCIAL SECURITY NO. 492-12-8674	17. INFORMANT Ann Stewart Address 2311 Biddle
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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) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH undet.
DUE TO (b) Arteriosclerosis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)		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 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
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21. I attended the deceased from 4-10-59 , to 4-18-59 and last saw him ^{her} alive on 4-18-59 Death occurred at 6:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE S. G. Drasen (Degree or title) M.D.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 4-20-59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE April 25/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cems	23d. LOCATION (City, town, or county) (State) St. Louis County
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24. FUNERAL DIRECTOR F. A. Heen ADDRESS 4214 Delmar av	25. DATE RECD. BY LOCAL REG. APR 22 '59	26. REGISTRAR'S SIGNATURE W. Earl 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 *J. A. Mean*

Licensed Embalmer No. *2963*
P. O. Address *4214 Delmar*

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.