

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018922
STATE FILE NUMBER
2 5050

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57
9
2
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	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		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		d. STREET ADDRESS (If outside, give location) 5948 Cote Brillante	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Belton Middle Last Bass			4. DATE OF DEATH Month 5 Day 21 Year 59		
--	--	--	---	--	--

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 Unknown Apt 60	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.
-----------------------	----------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Hope, Ark.	12. CITIZEN OF WHAT COUNTRY? USA.
---	--	---	---

13a. FATHER'S NAME Jim Bass	13b. MOTHER'S MAIDEN NAME Julia Grisby	14. NAME OF HUSBAND OR WIFE Leah Bass
---------------------------------------	--	---

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. -	17. INFORMANT Address Leah Bass-5948 Cote Brillante
--	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous Carcinoma of Lung Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 163x DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH undet.
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.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--

21. I attended the deceased from 5-15-59 to 5-21-59 and last saw ^{him} alive on 5-21-59 Death occurred at 8:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. A. Trax (Degree or title) _____	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 5-22-59
--	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-28-59	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) Berkeley MD
---	-----------------------------	--	---

24. FUNERAL DIRECTOR A. L. Bea Undertaking-Delmar	ADDRESS 4303	25. DATE RECD. BY LOCAL REG. MAY 25 59	26. REGISTRAR'S SIGNATURE Carl Smith. M.D.
---	---------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with date listed. 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 *A. D. Richards*

Licensed Embalmer No. *2928*

P. O. Address *City*

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.