

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023469
STATE FILE NUMBER

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **5613**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St Louis		c. CITY OR TOWN St Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Homer Phillips		d. STREET ADDRESS (If outside, give location) 2742 Delmar	
3. NAME OF DECEASED (Type or print) First Willie Middle Mal Last Toler		4. DATE OF DEATH Month 6 Day 10 Year 59	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 41
11. BIRTHPLACE (City and state or country) SHAW'S, Miss. 1		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Guffin		13b. MOTHER'S MAIDEN NAME Rosie Bush	
14. NAME OF HUSBAND OR WIFE		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. NONE		17. INFORMANT Steve Guffin Address 4850 St Louis Ave	
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 Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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.) 331X	
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	
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at 1220A on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE George M. Smith		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 6/12/59		23. NAME OF CEMETERY OR CREMATORY Franklin	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-15-59	
23c. LOCATION (City, town, or county) (State) Kirkwood MO		24. FUNERAL DIRECTOR Burke, 3506 Franklin ADDRESS	
25. DATE RECD. BY LOCAL REG. JUN 12 59		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be 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 *Leroy W. Barnister*

Licensed Embalmer No. *4523*

P. O. Address *4251 WASHINGTON*

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.