

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-042157

STATE FILE NUMBER

210658

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's 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) 2617 Cole	

3. NAME OF DECEASED (Type or print) First Middle Last Little			4. DATE OF DEATH Month Day Year 11 9 59			
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-16-59	9. AGE (last birthday) IF UNDER 1 YEAR Months Days Hours Min. 2 6
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Saint Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Jimmy Little	13b. MOTHER'S MAIDEN NAME Doris Futrell	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Hospital Records - 2601 N. Whittier	Address
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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) Premature birth		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (b) Subarachnoid Hemorrhage	
	DUE TO (c) 760.5	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Atelectasis	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 11-9-59 to 11-9-59 and last saw him alive on 11-9-59 Death occurred at 7:45 a. m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Park White, M.D.</i>	22b. ADDRESS 2601 N. Whittier	22c. DATE SIGNED 11-12-59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11-30-1959	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 Rowland Mortuary Svc. 4104-06 Manchester	25. DATE RECD. BY LOCAL REG. NOV 19 1959	26. REGISTRAR'S SIGNATURE <i>Rowland Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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.

X

Student _____
Signature of Student Embalmer

Signed _____

11-11-11

XX

11-11-11

11-11-11

Licensed Embalmer No. _____

P. O. Address _____

11-11-11

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.