

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 22 1960

60-003824

2 360

STATE FILE NUMBER

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 MO. b. COUNTY | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Length of stay in 1b 35 YRS. | | c. CITY OR TOWN ST. LOUIS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. HOMER G PHILLIPS | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3741 COOK AVE. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED First Middle Last CORNELIOUS MINOR | | | | 4. DATE OF DEATH Month Day Year JAN 8th / 60 | | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE NEGRO | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH JUN 18 1899 | | 9. AGE (last birthday) ABT-61 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (City and state or country) BROWNSVILLE, TENN | | 12. CITIZEN OF WHAT COUNTRY U S A | | | |
| 13a. FATHER'S NAME CORNELIOUS MINOR | | | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | | | 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. 495-18-4381A | | 17. INFORMANT Address MARY SMITH 4648 LEDUC | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Hypertension DUE TO (c) 443x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | | | 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 | | | |
| 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 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 Sept. 10 59 to Jan - 8 - 60 and last saw her/him alive on Jan - 8 Death occurred at 4 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE Delbert A. Younger MD (Degree or title) | | | | 22b. ADDRESS 4635 Easton | | | | 22c. DATE SIGNED 1/11/60 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE JAN. 15 - 60 | | 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK | | 23d. LOCATION (City, town, or county) ST. LOUIS, COUNTY, MO. | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS L.W. ANDERSON 4481 FINNEY AVE. | | | | 25. DATE RECD. BY LOCAL REG. JAN 12 1960 | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mdc

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arthur L. Hellier

Licensed Embalmer No. 4221

P. O. Address 3100 Eastern

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.