

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS FEB 25 1960



Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 18930-008873** STATE FILE NUMBER

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		Length of stay in 1b _____		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			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3901a Sullivan		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maggie Middle _____ Last Sherrod				4. DATE OF DEATH Month 2 Day 14 Year 60				
5. SEX Female	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 6/20/86	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days 24	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil.			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) Wentsville, Miss.	12. CITIZEN OF WHAT COUNTRY USA.		
13a. FATHER'S NAME James Brent			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE None			
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 Address Willie Short 3901 Sullivan 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) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____						
		DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Peripheral Vascular Insufficiency						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N: <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 _____ 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	
21. I attended the deceased from 12-31-59 to 2-14-60 and last saw her ^{her} alive on 2-14-60				Death occurred at 8:50 p. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE R. Schopp Jr MD (Degree or title)			22b. ADDRESS 2601 N. Whittier St.			22c. DATE SIGNED 2-15-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/18/60	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) St. Louis Co. Mo.		(State)		
24. FUNERAL DIRECTOR Wright Funeral Funeral 3100 Easton Ave			ADDRESS	25. DATE RECD. BY LOCAL REG. FEB 16 1960	26. REGISTRAR'S SIGNATURE Kearl Smith M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. Heillia

Licensed Embalmer No. 4221

P. O. Address 3100 Coast

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to do 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.