

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) 4244 W. Easton	

3. NAME OF DECEASED (Type or print) First Peter Middle L. Last Dorsey, Jr			4. DATE OF DEATH Month 8 Day 25 Year 60			
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 5-16-1901	9. AGE (last birthday) 59	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 (Refuge Dept)	10b. KIND OF BUSINESS OR INDUSTRY City of St. Louis	11. BIRTHPLACE (City and state or country) Viicksburg, Miss	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Peter Dorsey	13b. MOTHER'S MAIDEN NAME Regina Washington	14. NAME OF HUSBAND OR WIFE Cora Dorsey	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes w.w.2	16. SOCIAL SECURITY NO. 499-036895	17. INFORMANT Harriett Jenning 4322 Evans
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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) Laennec's Cirrhosis		INTERVAL BETWEEN ONSET AND DEATH Undet.
DUE TO (b)		
DUE TO (c) 581-1		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hepatic Cema		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 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.)
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20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____	Month, Day, Year
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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 7-30-60 to 8-25-60 and last saw xx him alive on 8-25-60 Death occurred at 8x88 12:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Sydney G. Mason, M.D.	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 8-26-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/30/60	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo
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24. FUNERAL DIRECTOR C.W. Roberts 2100. Co 1416 N. Taylor	25. DATE RECD. BY LOCAL REG. AUG 26 1960	26. REGISTRAR'S SIGNATURE Earl Smith M.D.
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.