DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10250

60-039844
STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: Unk.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2811 Franklin
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Rafe; Middle; Last: Houston
4. DATE OF DEATH: Month: 10; Day; Year: 60 — 10-16-60
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ 9
8. DATE OF BIRTH: 12-26-94
9. AGE (last birthday): 65
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): unk.
10b. KIND OF BUSINESS OR INDUSTRY: unk.
11. BIRTHPLACE (City and state or country): unk. 9
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Doc Houston
13b. MOTHER'S MAIDEN NAME: Lillie
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): 7-28-18 6-21 19
16. SOCIAL SECURITY NO.: unk.
17. INFORMANT: Hospital records
Address: 2601 No. Whittier

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Brain Syndrome
INTERVAL BETWEEN ONSET AND DEATH: undetermin.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 309 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Malnutrition, Hypovitaminosis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10-10-60 to 10-16-60 and last saw her/him alive on 10-16-60
Death occurred at P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Edward B. Willcomb M.D. (Degree or title)
22b. ADDRESS: 2601 N. Whittier
22c. DATE SIGNED: 10-16-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10/24/60
23c. NAME OF CEMETERY OR CREMATORY: Nat'l. (National)
23d. LOCATION (City, town, or county): Jafferson Barracks (State): Mo.
24. FUNERAL DIRECTOR: Jas H. Randle & Son
ADDRESS: 3133 Bell Ave.
25. DATE RECD. BY LOCAL REG.: OCT 22 1960
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

DOCUMENT

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_____ Signed Esther T. Harris

Signature of Student Embalmer

Licensed Embalmer No. 445

P. O. Address 4181 Wa

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