URT DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12545

-60-047472
STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 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): 4336 Easton
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Peter Middle: Last: Farris
4. DATE OF DEATH: Month 12 Day 24 Year 60
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 3/1/1888
9. AGE (last birthday): 72
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): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Tallahatchie Ct., Miss.
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Jack Farris
13b. MOTHER'S MAIDEN NAME: Eliza Lester
14. NAME OF HUSBAND OR WIFE: Deceased
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Nellie Hampton Address: 4336 Easton Ave.

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): Congestive Heart Failure — 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): 434.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Chronic Brain Syndrome
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 12-6-60, to 12-24-60 and last saw ~~xx~~ him alive on 12-24-60
Death occurred at 3:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or Title): Sydney A. Fraser, M.D.
22b. ADDRESS: 2601 N. Whittier St.
22c. DATE SIGNED: 12-27-60
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 12/30/60
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Missouri
24. FUNERAL DIRECTOR: E. S. Koonce ADDRESS: 1221 North Grand
25. DATE RECD. BY LOCAL REG.: DEC 29 1960
26. REGISTRAR'S SIGNATURE: Karl Smith M.D.

BY AFFIDAVIT OF 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_____
Signature of Student Embalmer

Signed Melvin Blankenship

Licensed Embalmer No. 3962

P. O. Address 1221 N Bu

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.