

DEC 23 1960

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-60-047675

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **11756** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		a. STATE Missouri COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Homer G. Phillips		c. CITY OR TOWN Saint Louis	
Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 742 Bayard	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last JOHN HENRY LEE			Month Day Year December 4, 1960		
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 10/28/92	9. AGE (last birthday) 68	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Millend Drapery		11. BIRTHPLACE (City and state or country) Lake Providence, La. U.S.A.	
13a. FATHER'S NAME Asberry Lee		13b. MOTHER'S MAIDEN NAME Iceyphine Powell		14. NAME OF HUSBAND OR WIFE Senora Lee	
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. 498-09-0428		17. INFORMANT Address Senora Lee 742 Bayard	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Ruptured Dissecting Aneurysm of Aorta**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) **751x**

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ **750 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul J. Simon (Degree) Deputy Coroner	22b. ADDRESS 300 Clark	22c. DATE SIGNED 12/7/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/9/60	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR ADDRESS Charles J. Gates, 4107 Finney	25. DATE RECD. BY LOCAL REG. DEC 7 1960	26. REGISTRAR'S SIGNATURE Leah 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Geyton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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