

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

2375

61-011787

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED

FILED MAR 23 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | | |
|---|------------------|---|---|--|---|--|--|---|----------------|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | St. Louis | | | Missouri | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Homer G. Phillips | | | | | 1734 Franklin | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | First | Middle | Last | 4. DATE OF DEATH Month Day Year | | |
| Charlie | | | | | | Willis | 3 8 61 | | |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | IF UNDER 1 YEAR | IF UNDER 24 HR |
| Male | Negro | | | 11-4-1909 | | 51 YRS | | 4 Months 8 Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or country) | | 12. CITIZEN OF WHAT COUNTRY | | |
| LABORER | | | Kiel Auditorium | | JACKSON, TENN | | U. S. A | | |
| 13a. FATHER'S NAME | | | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | | | |
| Ned Willis | | | | PEARL WOMACK | | - | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | | 17. INFORMANT Address | | | | |
| NO | | | | | Mrs Pearl Stamps 1734 Franklin | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Lobar Pneumonia | | | | | | | | Undet. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) | | DUE TO (c) | | 526x | | | |
| 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. | |
| Cor Pulmonale, Bronchiectasis, Chronic | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 3-3-61 to 3-8-61 and last saw him live on 3-8-61 | | | | Death occurred at 3:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Sydney R. Frase, M. D. | | | | 22b. ADDRESS 2601 N. Whittier St. | | 22c. DATE SIGNED 3-10-61 | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | (State) | |
| REMOVAL | | 3-14-61 | | GREENWOOD Cem | | ST. LOUIS city | | MO | |
| 24. FUNERAL DIRECTOR A. F. WALTON 2707 STODDARD ST. | | | | 25. DATE RECD. BY LOCAL REG. MAR 11 1961 | | 26. REGISTRAR'S SIGNATURE Neal Smith M.D. | | | |

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. Claude Gordon

10-2-2

xx

10-2-2

10-2-2

Licensed Embalmer No. 3489

60:8

P. O. Address 1123 N Taylor

10-2-2

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