ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6516 STATE FILE NUMBER 61-027092

FILED JUL 25 1961

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 (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): 1807 N. Garrison
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Louis; Middle; Last: Mack
4. DATE OF DEATH: Month 7 Day 11 Year 61
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 5-7-'03
9. AGE (last birthday): 58
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): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): LOUISIANA
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: UNKNOWN
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: DECEASED
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: CORNELIA SMITH Address: 1807 N. GARRISON

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): Uncontrolled Diabetes — 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): 260x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Left Scrotal Infection with Abscess
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 7-6-61, to 7-11-61 and last saw her/him alive on 7-11-61
Death occurred at 11:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: B. Prophete MD (Degree or title)
22b. ADDRESS: 2601 N. Whittier
22c. DATE SIGNED: 7-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 7-17-61
23c. NAME OF CEMETERY OR CREMATORY: FATHER DICKSON CEM.
23d. LOCATION (City, town, or county): ST. LOUIS COUNTY (State): MO.
24. FUNERAL DIRECTOR: Luke Jones ADDRESS: 1343 N. Garrison
25. DATE RECD. BY LOCAL REG.: JUL 13 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | 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 me, or by _____ Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jefferson McClendon

Licensed Embalmer No. 5072

P. O. Address 4535 Wash

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.