

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9233** STATE FILE NUMBER

AMENDED FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. 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 <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) 1155 Bayard		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Robert Middle Last Irons			4. DATE OF DEATH Month 10 Day 3 Year 61			
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/26/25	9. AGE (last birthday) 36	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and state or country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Lonnie Irons	13b. MOTHER'S MAIDEN NAME Viola Ward	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes	16. SOCIAL SECURITY NO. UNK	17. INFORMANT Jessie Davis, 1155 Bayard	Address
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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) Pulmonary Edema		Undet.
DUE TO (b) Hypertensive Cardiovascular Disease		Undet.
DUE TO (c) 443x		

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from 9-21-61 to 10-3-61 and last saw her alive on 10-3-61
Death occurred at 9:55 p. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J.H. Zeller, M.D. (Degree or title)	22b. ADDRESS 2601 N. Whittier Street	22c. DATE SIGNED 10-4-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/9/61	23c. NAME OF CEMETERY OR CREMATORY Greenwood	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo
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24. FUNERAL DIRECTOR Green Funeral Home, 4060	ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 6 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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 Melvin E. Green

Licensed Embalmer No. 4428

P. O. Address St. Louis, Mo.

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.