

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
 Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9506** STATE FILE NUMBER **-61-038501**

AMENDED FILED OCT 26 1961

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| 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. CITY OR TOWN St. Louis |
| 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) 3620 Cottage |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Ida Middle Easter Last Easter | | | 4. DATE OF DEATH Month 10 Day 11 Year 61 | | | |
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|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1-20-1893 | 9. AGE (last birthday) 68 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 10b. KIND OF BUSINESS OR INDUSTRY NONE | 11. BIRTHPLACE (City and state or country) South Carolina | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
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| 13a. FATHER'S NAME HENRY Calhoun | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE NONE |
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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) No | 16. SOCIAL SECURITY NO. ? | 17. INFORMANT Oscar Easter | Address 3620 Cottage |
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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: IMMEDIATE CAUSE (a) Myocardio Infarction | | INTERVAL BETWEEN ONSET AND DEATH Undet. |
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| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | DUE TO (c) 4201 |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 9:05 a.m. Month, Day, Year 10-10-61 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION St. Louis | COUNTY | STATE |
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| 21. I attended the deceased from 10-10-61 9:05 a.m. to 10-11-61 and last saw her/him alive on 10-11-61 Death occurred at 2:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE Char. L. Tombe, M.D. | (Degree or title) | 22b. ADDRESS 2601 N. Whittier Street | 22c. DATE SIGNED 10-11-61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 10-26-61 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park | 23d. LOCATION (City, town, county) (State) St. Louis City, Mo. |
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| 24. FUNERAL DIRECTOR Thomas Jackson | ADDRESS 2741 Dickson | 25. DATE RECD. BY LOCAL REG. OCT 14 1961 | 26. REGISTRAR'S SIGNATURE Paul Smith |
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DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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

Leroy H. Lammister

Licensed Embalmer No. 4523

P. O. Address 4251 W. ...

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.