

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

34411
9245

State File No. _____
Registrar's No. _____

Registration District No. **318** Primary Registration District No. **100**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Hoher G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 days**
In this community **20 yrs.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **oas**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4458 Evans**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ada Long**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Colored**
6. (a) Single, widowed, married, divorced **Wid. 2**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec. 27 1888**
(Month) (Day) (Year)

8. AGE: Years **59** Months **9** Days **25**
If less than one day _____ hr. _____ min.

9. Birthplace **Miss.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Domestic (Housewife)**

11. Industry or business _____
12. Name **John Harris**
13. Birthplace **Miss.**
(City, town, or county) (State or foreign country)
14. Maiden name **Clarrise Harris**
15. Birthplace **Miss.**
(City, town, or county) (State or foreign country)

16. (a) Informant **John H. Gregg (Son)**
(b) Address **4458 Evans Avenue**
17. (a) **Burial** (b) Date thereof **10-27-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park Ceme.**

18. (a) Signature of funeral director **Peoples' Und. Co**
(b) Address **3100 Franklin Avenue**
19. (a) **OCT 26 1948** (b) **J. B. Kasater**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **22**
year **1948** hour **5** minute **40 a. m.**
21. I hereby certify that I attended the deceased from **Oct. 16**, 19 **48** to **Oct. 22**, 19 **48**
that I last saw her alive on **October 22**, 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Cardiovascular Disease**
Due to _____
Due to _____

Other conditions **Hypertensive Encephalopathy**
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy **None**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(c) means of injury _____
23. Signature **Oliver L. Daniels** (M. D. or other)
Address **2601 N Whittier** Date signed **10/22/48**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

John H. Petrus

Licensed Embalmer No. *4184*

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 this body is not embalmed, fact should be so stated above.