

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13836

State File No. 3547

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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, write RURAL and give township) OR TOWN ST. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 3500. A. Lawton Blvd.	
3. NAME OF DECEASED (Type or Print) a. (First) Effie b. (Middle) Lee c. (Last) Hill			4. DATE OF DEATH (Month) (Day) (Year) April 16 1949
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 11, 1897
9. AGE (In years last birthday) 51		IF UNDER 1 YEAR Months 4 Days 5	IF UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Domistictics	11. BIRTHPLACE (State or foreign country) Atlanta Georgia/
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME George Simpson	
13b. MOTHER'S MAIDEN NAME Lela King		14. NAME OF HUSBAND OR WIFE Capron Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. -	
17. INFORMANT'S SIGNATURE OR NAME Capron Hill		ADDRESS 3500. A. Lawton	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism ANTECEDENT CAUSES DUE TO (b) Undetermined DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 467			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 155 X			
22. I hereby certify that I attended the deceased from 3-16 , 19 49 , to 4-16 , 19 49 , that I last saw the deceased alive on 4-16 , 19 49 , and that death occurred at 12:45pm. , from the causes and on the date stated above.			
23a. SIGNATURE Charles R. Hozer		(Degree or title) M. D. D.	
23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 4-19-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-23-49	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) ST. Louis MO	
DATE REC'D BY LOCAL REG. APR 20 1949		REGISTRAR'S SIGNATURE J. B. Jansen	
25. FUNERAL DIRECTOR'S SIGNATURE C. B. Jordan		ADDRESS 3955, Page Blvd	

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

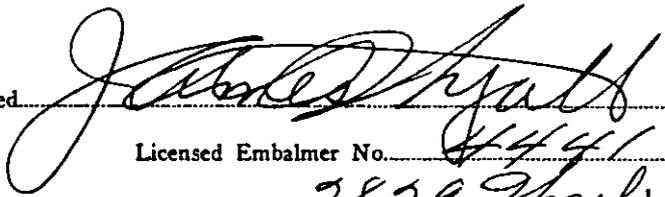
STATEMENT BY LICENSED EMBALMER

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
Student Embalmer

Signed 

Licensed Embalmer No. 4441

P. O. Address 2829 Washington

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.