

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3288

No. 300
10.48

FILED APR 21 1949

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

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

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) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 3814 Laclède Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Grace b. (Middle) Washington c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) April 8 1949		
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5. SEX Fem 3	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH Feb. 20, 1885	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 2	IF UNDER 4 WKS. Days 18	IF UNDER 4 WKS. 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	11. BIRTHPLACE (State or foreign country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Jim Davis	13b. MOTHER'S MAIDEN NAME Sallie Phillips	14. NAME OF HUSBAND OR WIFE Albert Washington
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 44K	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Opheelia Herndon
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION - Intestinal Tract		INTERVAL BETWEEN ONSET AND DEATH Undet.
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Carcinoma of Lower		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Uremia DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-29, 1949, to 4-8, 1949, that I last saw the deceased alive on 4-8, 1949, and that death occurred at 7:56a m., from the causes and on the date stated above.

22a. SIGNATURE Oscar L. Daulton (Degree or title) M. D. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 4-9-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/13/49	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis County, MO
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DATE REC'D BY LOCAL REG. APR 12 1949	REGISTRAR'S SIGNATURE J. B. Looater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS T. M. C. Green - 3517 Laclède
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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 _____

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