

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17280
Registrar's No. 4725

FILED JUN 7 1949

REG. DIST. NO. 318 PRIMARY REG. DIST. 1003

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) 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 Homer G Phillips Hospital | | d. STREET ADDRESS (If rural, give location) 705 N Leonard | |
| 3. NAME OF DECEASED (Type or Print) Eliza Gibson | | | 4. DATE OF DEATH (Month) (Day) (Year) May 17 1949 |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH July 20, 1892 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 56 |
| 11. BIRTHPLACE (State or foreign country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Charlie Williams | | 13b. MOTHER'S MAIDEN NAME ? | 14. NAME OF HUSBAND OR WIFE None noted |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk | | 16. SOCIAL SECURITY NO. Unk | 17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier St |
| 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) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Chronic Nephritis Undetermined II. OTHER SIGNIFICANT CONDITIONS disease with Gangrene of Toes Arteriosclerotic peripheral vascular | |
| 19a. DATE OF OPERATION 1-19-49 | | 19b. MAJOR FINDINGS OF OPERATION Transmetatarsal Amputation left toe | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21. INTERVAL BETWEEN ONSET AND DEATH 4 mos | |
| 21a. ACCIDENT SUICIDE HOMICIDE No | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 1-2-19 49 to 5-17 19 49 that I last saw the deceased alive on 5-17 19 49, and that death occurred at 5:45a m., from the causes and on the date stated above. | | | |
| 23a. SIGNATURE Oscar D Daniels | | 23b. ADDRESS (Degree or title) M. D. | 23c. DATE SIGNED 5-20-49 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) MAY 31 1949 | | 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board | |
| 24b. DATE | | 24d. LOCATION (City, town, or county) (State) | |
| DATE REC'D BY LOCAL REG. MAY 31 1949 | | REGISTRAR'S SIGNATURE J. B. Fosater | |
| 25. FUNERAL HOME | | 25. FUNERAL HOME Roman's Mortuary Services 4104 Manchester Ave. | |

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.

P. O. Address.....

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.