

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17460
4573

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1000 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give town or town St Louis;		a. STATE Missouri	b. COUNTY
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St Louis;	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4125 W. Belle Pl.	

3. NAME OF DECEASED (Type or Print) Maud	a. (First)	b. (Middle) Lockett	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 5, 22 1949
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Single	8. DATE OF BIRTH SEPT-16-1908	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) MEMPHIS TENN	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME GEORGE WOODS	13b. MOTHER'S MAIDEN NAME Lucy BUCHANAN	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY No 493-20-8543	17. INFORMANT'S SIGNATURE OR NAME ADDRESS HERBERT CARUTHER 4125 W BELLE
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pancreatic Necrosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 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 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? 128 5/27/49
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) 3	23b. ADDRESS 300 Clark Ave	23c. DATE SIGNED 5/24/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 5-27-49	24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	24d. LOCATION (City, town, or county) (State) ST LOUIS CO.
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DATE REC'D BY LOCAL REG. MAY 24 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C W ROBERTS 1416 N TAYLOR AVE
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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 *Fulton E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address *13*

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.