

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20850
State File No. 4838

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Saint Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Saint Louis</u>		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1315 N. Whittier</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mollie</u> b. (Middle) _____ c. (Last) <u>Byrd</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5-29-49</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>10-20-1874</u>	
9. AGE (In years last birthday) <u>74</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Springfield, Ark</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13a. FATHER'S NAME <u>John Strassner</u>			
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Viola Smith</u> ADDRESS <u>1315 N. Whittier</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Failure</u> <u>Hypertensive Heart Disease with</u> INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u> ANTECEDENT CAUSES DUE TO (b) <u>Cerebral Hemorrhage</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES ☐ NO ☒			
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) <u>St. Louis</u> (STATE) <u>Mo</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? <u>H343</u>					
22. I hereby certify that I attended the deceased from <u>5-20</u> , 19 <u>49</u> , to <u>5-29</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>5-23</u> , 19 <u>49</u> , and that death occurred at <u>10:53p m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Olson Daniels</u> M. D. <u>U</u>				23b. ADDRESS <u>2601 N. Whittier St</u>		23c. DATE SIGNED <u>6-1-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>6/4/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Booker Washington</u>		24d. LOCATION (City, town, or county) (State) <u>East St. Louis, Ill.</u>	
DATE REC'D BY LOCAL <u>JUN 3 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Sauter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Wade Cronberry</u> ADDRESS <u>4202 Finney</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Leroy W. Bannister

Licensed Embalmer No. *45-23*

P. O. Address *3880 - Easton Ave*

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.