

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21238**
5864

FILED JUL 15 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **100** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Mad	
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 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1925 Bellemeade	

3. NAME OF DECEASED (Type or Print)	a. (First) Sarah	b. (Middle)	c. (Last) Jones	4. DATE OF DEATH (Month) (Day) (Year) June 30 1949
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5. SEX F. 3	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 7	8. DATE OF BIRTH 5-15-1893	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Paducah Ky. 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Thomas Allen Elliot	13b. MOTHER'S MAIDEN NAME Mary Linper	14. NAME OF HUSBAND OR WIFE deceased
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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.	17. INFORMANT'S SIGNATURE OR NAME Ardella Smith 1928th Boulevard	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Vulva		INTERVAL BETWEEN ONSET AND DEATH Undet.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 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) 44th
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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? 176A
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22: I hereby certify that I attended the deceased from **6-24**, 19**49**, to **6-30**, 19**49**, that I last saw the deceased alive on **6-30**, 19**49**, and that death occurred at **3 p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Walter B. Bazeman M. D.	23b. ADDRESS 2601 N White St.	23c. DATE SIGNED 7-2-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-6-49	24c. NAME OF CEMETERY OR CREMATORY Oakdale Cem.	24d. LOCATION (City, town, or county) (State) St. Louis
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Sessler	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman L. Allen 4254 W. Frimley
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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 Leroy W. Bannister

Licensed Embalmer No. 4523

P. O. Address 3880th Euston 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.