

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21578

State File No. _____

318

1003

5250

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>ST LOUIS MO</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS MO</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Louis 3</u>		c. LENGTH OF STAY (in the place) <u>15 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>RURAL WEBSTER GROVES</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST MARYS INF. NR 125 THORNTON</u>				d. STREET ADDRESS (If rural, give location) <u>NR 125 THORNTON</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>HAZEL</u>			b. (Middle)			c. (Last) <u>RENFRO</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 15 1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>Oct 7-1901</u>		9. AGE (In years last birthday) <u>47</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u>		IF UNDER 1 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MOZELL Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>LEE WHITE</u>		13b. MOTHER'S MAIDEN NAME <u>MRS GOOD</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Henry Renfro</u>		ADDRESS <u>125 Thornton</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ESSENTIAL HYPERTENSION</u> ANTECEDENT CAUSES <u>SUBCHRONIC HEMORRHOID</u> DUE TO (b) <u>HIGH BLOOD PRESSURE</u> DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>				INTERVAL BETWEEN ONSET AND DEATH <u>June 1-15 1949</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>WEBSTER GROVES ST LOUIS MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>June 1, 1949</u> , to <u>June 15, 1949</u> , that I last saw the deceased alive on <u>June 15, 1949</u> , and that death occurred at <u>4:42 AM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Frances D. Anderson MD</u>				23b. ADDRESS <u>2630 Franklin St. Hann</u>		23c. DATE SIGNED <u>6-17-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>none</u>		24b. DATE <u>JUNE 18-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FATHER DICKSON</u>		24d. LOCATION (City, town, or county) (State) <u>KIRKWOOD MO</u>	
DATE REC'D BY LOCAL REG. <u>SUN 17 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Sarsater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frances D. Anderson</u>		ADDRESS <u>14 Wayman Webster Groves, Mo.</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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed *Richard J. Yaunder*

Licensed Embalmer No. *14245*

P. O. Address *14 W. Depue*

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.