

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27996

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. 7440

1. PLACE OF DEATH a. COUNTY St. Louis, Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	17
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 10 - 4578a St. Louis, Mo	

3. NAME OF DECEASED (Type or Print) Cynthia	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) August 24 1949
--	------------	-------------	-----------	---

5. SEX Female	6. COLOR OR RACE 3 Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH/ Nov. 23, 1909	9. AGE (In years last birthday) 39	10. UNDER 1 YEAR Months 9	11. UNDER 24 HRS. Days 1	Hours	Min.
------------------	-----------------------------	---	------------------------------------	------------------------------------	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Aberdine, Miss.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	--	---------------------------------------

13a. FATHER'S NAME John Adams	13b. MOTHER'S MAIDEN NAME Estella Jouniking	14. NAME OF HUSBAND OR WIFE Alvin Duncan
----------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. Notary	17. INFORMANT'S SIGNATURE OR NAME Mr. Alvin Duncan	ADDRESS 4578a St. Louis Av
--	-----------------------------------	---	-------------------------------

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Hypertension		INTERVAL BETWEEN ONSET AND DEATH Undet.
	ANTECEDENT CAUSES Azotemia		Undet.
	DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) None		
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 checked="" type="checkbox"/>
------------------------	----------------------------------	---

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) 102
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H H H H
---	--	---------------------------------------

22. I hereby certify that I attended the deceased from 8-22, 19 49, to 8-24, 19 49, that I last saw the deceased alive on 8-24, 19 49, and that death occurred at 12:55 p.m., from the causes and on the date stated above.

23a. SIGNATURE James J. Hedrick	(Degree of title) M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 8-25-49
------------------------------------	----------------------------	------------------------------------	-----------------------------

24. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Aug 27-1949	24c. NAME OF CEMETERY OR CREMATORY Shipped	24d. LOCATION (City, town, or county) (State) Okolona, Miss
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. AUG 26 1949	REGISTRAR'S SIGNATURE J. B. Sauter	25. FUNERAL DIRECTOR'S SIGNATURE Moses Adams	ADDRESS 3849 Windsor Place
---	---------------------------------------	---	-------------------------------

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 F. C. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.