

FILED AUG 20 1949

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

28305

State File No. 6968  
 Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St Louis		c. CITY OR TOWN St Louis 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 21 2800 Franklin	

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) c. (Last) McCormack		4. DATE OF DEATH (Month) (Day) (Year) Aug. 7 1949	
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid. 2	8. DATE OF BIRTH June 3, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 60
11. BIRTHPLACE (State or foreign country) Ark.		12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME Brown McClendon	13b. MOTHER'S MAIDEN NAME Ellen Brown	14. NAME OF HUSBAND OR WIFE widow
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 AND ADDRESS Berrie James 2800 Franklin

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of left Breast with Post-Operative Simple Mastectomy		
	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. 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) 50
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? 198X

22. I hereby certify that I attended the deceased from 7-15, 1949, to 8-7, 1949, that I last saw the deceased alive on 8-7, 1949, and that death occurred at 4 p m., from the causes and on the date stated above.

22a. SIGNATURE Charles Frazier M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 8-8-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Stopped	24b. DATE Aug 16/49	24c. NAME OF CEMETERY OR CREMATORY Clarksdale
24d. LOCATION (City, town, or county) (State) Miss		

DATE REC'D BY LOCAL REG. AUG 10 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS F. C. [Signature] 4214 Delmar
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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

*F. G. 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.