No. 300
10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED AUG 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28568

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6999

1. PLACE OF DEATH
a. COUNTY 4361-Labadie Ave.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis Mo.
c. LENGTH OF STAY (In this place) 40 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4361 Labadie Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY
c. CITY (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 4238 W Ashlandd

3. NAME OF DECEASED (Type or Print)
a. (First) Viola
b. (Middle)
c. (Last) Stanley

4. DATE OF DEATH (Month) 8 (Day) 10 (Year) 1949

5. SEX Femaie
6. COLOR OR RACE Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH March, 3, 1889
9. AGE (In years last birthday) 60 — If under 1 year: Months 5, Days 7 — If under 24 hrs.: 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) Madison Parish Louisana.
12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Henry Watts.
13b. MOTHER'S MAIDEN NAME Nettie Franklin
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mrs. Ella Carter **ADDRESS** 4748 Vernon Ave.

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pernicious Anemia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Age

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. NO

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) St Louis **(COUNTY)** 730 **(STATE)** MO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 2004

22. *I hereby certify that I attended the deceased from* 8/7 *, 1949, to* 8/10 *, 1949, that I last saw the deceased alive on* 8/9 *, 1949, and that death occurred at* 12 00 *m., from the causes and on the date stated above.*

23a. SIGNATURE T Walker M.D. **(Degree or title)**
23b. ADDRESS 809a N Jefferson Ave
23c. DATE SIGNED 8/10/49

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE 8/12/49
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) 6571 St. Louis Ave. St. Louis Mo. **(State)**

DATE REC'D BY LOCAL REG. AUG 11 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR'S SIGNATURE Herman J. Smith Funeral Home **ADDRESS** 4247 W labadie

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed [illegible]

Signed.....
Student Embalmer

Licensed Embalmer No. 4341

P. O. Address [illegible] Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.